Public Document Pack

A&B HSCP Transforming Together

Argyll & Bute Health & Social Care Partnership

18 May 2022

NOTICE OF MEETING

A meeting of the **ARGYLL AND BUTE HSCP INTEGRATION JOINT BOARD (IJB)** will be held by **MICROSOFT TEAMS** on **WEDNESDAY, 25 MAY 2022** at **1:00 PM**, which you are requested to attend.

BUSINESS

1. **APOLOGIES FOR ABSENCE**
2. **DECLARATIONS OF INTEREST**
3. **MINUTES** (Pages 3 - 8)

   Argyll and Bute HSCP Integration Joint Board held on 30 March 2022
4. **MINUTES OF COMMITTEES**

   (a) Audit and Risk Committee held on 12 April 2022 (Pages 9 - 12)

   (b) Clinical and Care Governance Committee held on 28 April 2022 (Pages 13 - 18)

   (c) Finance and Policy Committee held on 18 March 2022 (Pages 19 - 22)

   (d) Finance and Policy Committee held on 29 April 2022 (Pages 23 - 26)

   (e) Special Strategic Planning Group held on 27 April 2022 (Pages 27 - 28)
5. **CHIEF OFFICERS REPORT** (Pages 29 - 32)

   Report by Chief Officer
6. **APPOINTMENT OF ELECTED MEMBERS TO THE IJB AND REPRESENTATION ON THE IJB COMMITTEE STRUCTURE** (Pages 33 - 58)

   Report by IJB Standards Officer/Executive Director
7. **STAFF GOVERNANCE REPORT FOR FINANCIAL QUARTER 4 (2021/22)** (Pages 59 - 88)

   Report by HR People Partner
8. **WHISTLEBLOWING REPORT QUARTER 4 - 1 JANUARY 2022 TO 31 MARCH 2022** (Pages 89 - 106)

   Report by Director of People and Culture
9. **HEALTH AND SOCIAL CARE WORKFORCE STRATEGY: THREE YEAR WORKFORCE PLAN** (Pages 107 - 110)

   Report by HR People Partner

10. **COVID-19 PUBLIC HEALTH UPDATE** (Pages 111 - 138)

    Report by Associate Director of Public Health

11. **INTEGRATION JOINT BOARD - PERFORMANCE REPORT (MAY 2022)** (Pages 139 - 148)

    Report by Head of Strategic Planning, Performance and Technology

12. **JOINT STRATEGIC PLAN (2022-2025)** (Pages 149 - 634)

    Report by Head of Strategic Planning, Performance and Technology

13. **FINANCE**

    Report(s) by Head of Finance and Transformation

    (a) Provisional Year End Finance Position 2021-22 (Pages 635 - 650)

14. **UPDATED MODEL CODE OF CONDUCT AND ARGYLL AND BUTE IJB STANDING ORDERS** (Pages 651 - 690)

    Report by Business Improvement Manager

15. **ADOPTION OF MODEL COMPLAINTS HANDLING PROCEDURE OF THE SCOTTISH GOVERNMENT, SCOTTISH PARLIAMENT AND ASSOCIATED PUBLIC AUTHORITIES IN SCOTLAND FOR THE INTEGRATION JOINT BOARD** (Pages 691 - 714)

    Report by Business Improvement Manager

16. **DATE OF NEXT MEETING**

    24 August 2022

Argyll and Bute HSCP Integration Joint Board (IJB)

Contact: Lynsey Innis, Tel: 01546 604338

MINUTES of MEETING of ARGYLL AND BUTE HSCP INTEGRATION JOINT BOARD (IJB) held VIA MICROSOFT TEAMS on WEDNESDAY, 30 MARCH 2022

Present: Sarah Compton Bishop, NHS Highland Non-Executive Board Member (Chair)
Councillor Kieron Green, Argyll and Bute Council (Vice Chair)
Councillor Robin Currie, Argyll and Bute Council
Councillor Sandy Taylor, Argyll and Bute Council
Gerard O'Brian, NHS Highland Non-Executive Board Member
Graham Bell, NHS Highland Non-Executive Board Member
Susan Ringwood, NHS Highland Non-Executive Board Member
Fiona Broderick, Lead Staffside Representative
David Gibson, CSWO. Head of Children, Families and Justice
Linda Currie, Associate Director AHP, NHS Highland
James Gow, Head of Finance and Transformation, Argyll and Bute HSCP
Elizabeth Higgins, Associate Director of Nursing, NHS Highland
Kenny Mathieson, Public Representative
Angus McTaggart, GP Representative, Argyll and Bute HSCP
Kirstie Reid, Carers Representative, NHS Highland
Dr Nicola Schinaia, Associate Director of Public Health, Argyll and Bute HSCP
John Stevens, Carers Representative, NHS Highland
Takki Sulaiman, Chief Executive, Argyll and Bute Third Sector Interface
Fiona Thomson, Lead Pharmacist
Dr Angus McTaggart, GP representative
George Morrison, Depute Chief Officer

Attending: Caroline Cherry, Head of Older Adults and Community Hospitals
Charlotte Craig, Business Improvement Manager
Abbie McIver, Principal Accountant
Lorna Jordan, Principal Accountant
Jean Boardman, NHS Highland Non-Executive Board Member
Evan Beswick, Head of Primary Care
Jane Fowler, Head of Customer Support Services
David Ritchie, Communications Manager
Dr Tim Allison, Director of Public Health
Fiona Hogg, Director of People and HR
Hazel MacInnes, Committee Services Officer, Argyll and Bute Council

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Gary Mulvaney, Fiona Davies, Dr Rebecca Helliwell and Margaret McGowan.

2. DECLARATIONS OF INTEREST

Graham Bell declared an interest in item 12 of the agenda (National Strategy for Community Justice – Analysis of Responses) as he was a non-executive member of Community Justice Scotland.

3. MINUTES

The Minutes of the meeting of the Integration Joint Board held on 26 January 2022 were approved as a correct record.

4. MINUTES OF COMMITTEES

(a) Audit and Risk Committee held on 15 February 2022

The Minutes of the meeting of the Audit and Risk Committee held on 15 February 2022 were noted.

The Chair of the Committee, Councillor Sandy Taylor, advised that the draft Annual Report was currently out for comment.

(b) Clinical and Care Governance Committee held on 24 February 2022

The Minutes of the meeting of the Clinical and Care Governance Committee held on 24 February 2022 were noted.

(c) Finance and Policy Committee held on 25 February 2022

The Minutes of the meeting of the Finance and Policy Committee held on 25 February 2022 were noted.

(d) Strategic Planning Group held on 3 March 2022

The Minutes of the meeting of the Strategic Planning Group held on 3 March 2022 were noted.

(e) Finance and Policy Committee held on 18 March 2022

The Minutes of the meeting of the Finance and Policy Committee held on 18 March 2022 were noted.

The Chair of the Committee, Councillor Kieron Green, advised that the Committee had been asked to review and endorse the budget proposals, but as the equality impact assessments had not been available for consideration at the meeting, the Committee had reviewed the proposals but had been unable to endorse them.

5. CHIEF OFFICER'S REPORT

The Board gave consideration to a report from the Chief Officer covering the Chief Officer appointment, service visits, Chief Officer podcast, award winning Argyll and Bute Community Addictions Nurse, national no smoking day, our winning diabetes team, senior management appointments and Argyll and Bute Suicide Prevention Group.

The Head of Finance, on behalf of the Chief Officer, advised that the previous day letters had been issued centrally with incorrect vaccination appointments, which was a similar issue to that which had taken place the previous autumn. He advised that these appointments would be cancelled and new appointments issued locally.

Decision

The Integration Joint Board noted the report by the Chief Officer and the verbal update from the Head of Finance.

(Reference: Report by Chief Officer dated 30 March 2022, submitted)

6. COVID-19 PUBLIC HEALTH UPDATE

The Board gave consideration to a report reviewing the work of Public Health in relation to Covid-19. The report built on accounts provided in earlier reports and presented the most up to date information as possible on how the pandemic was unfolding in Argyll and Bute as well as how the next phase of the pandemic response was developing in Scotland.

Decision

The Integration Joint Board noted the Covid-19 current status in the Argyll and Bute community, in terms of:

- Distribution of infection rates;
- Covid-19 vaccination;
- Covid-19 testing programmes.

(Reference: Report by Associate Director of Public Health dated 30 March 2022, submitted)

7. STAFF GOVERNANCE REPORT FOR FINANCIAL QUARTER 3 - 2021/2022

The Board gave consideration to a report on staff governance performance covering financial quarter 3 (October to December 2021) and the activities of the Human Resources and Organisational Development teams.

Decision

The Integration Joint Board –

1. Noted the content of the quarterly report on the staff governance performance in the HSCP.

2. Endorsed the overall direction of travel noting that it would be helpful to have comparative information from both the HSCP and the Council at future meetings.

(Reference: Report by Head of Customer Support Services dated 30 March 2022, submitted)

8. WHISTLEBLOWING REPORT QUARTER 3

The Board gave consideration to the third quarterly Whistleblowing Standards report for NHS Highland covering the period 1 October 2021 to 31 December 2021.

Decision

The Integration Joint Board noted the content of the report.

(Reference: Report by Director of People and Culture dated 30 March 2022, submitted)

9. ARGYLL AND BUTE HSCP STRATEGIC COMMISSIONING PLAN

The first Joint Strategic Commissioning Strategy covering the period April 2022 to March 2025 was before the Board for approval.

Decision

The Integration Joint Board approved the HSCP Joint Commissioning Strategy 2022-2025 for implementation.

(Reference: Report by Head of Strategic Planning, Performance and Technology dated 30 March 2022, submitted)

10. INTEGRATION JOINT BOARD - PERFORMANCE REPORT (MARCH 2022)

The Board gave consideration to a report providing an update on the impact on service performance with regards to the Covid-19 pandemic and the progress made with regard to remobilising health and social care services in Argyll and Bute.

Decision

The Integration Joint Board –

1. Noted the HSCP performance progress regarding remobilisation of activity in line with NHS Highland performance target for 2021/22 agreed with Scottish Government to 70%-80% of 2019/20 activity as at November 2021.

2. Noted Waiting Times Performance and a further reduction in Consultant and Nurse Led Outpatient breaches greater than 12 weeks.

3. Acknowledged performance with regards to both Argyll and Bute, and Greater Glasgow and Clyde current Treatment Time Guarantee for Inpatient/Day Case Waiting List and activity.

(Reference: Report by Head of Planning, Performance and Technology dated 30 March 2022, submitted)

11. FINANCE

(a) Budget Monitoring

The Board gave consideration to a report providing a summary of the financial position of the HSCP for the 11 months to 28 February 2022 and an updated forecast. The year to date position was an underspend totalling £224k against a budget to date of £272m.

Decision

The Integration Joint Board noted –

1. That the forecast outturn position was an underspend of £250k.

2. The additional funding allocation by the Scottish Government and the terms

associated with it as contained within appendix 4 to the submitted report.

3. That unspent funds would be carried forward as earmarked reserves.

4. That the HSCP now expected to repay debt owed to Argyll and Bute Council early, estimated at an additional payment totalling £1.8m.

5. That there was a year to date underspend of £224k at 28 February 2022.

(Reference: Report by Head of Finance and Transformation dated 30 March 2022, submitted)

(b) **Budget 2022/23 and Savings Plan**

The Board gave consideration to a report providing a proposed budget and associated savings plan for 2022/23 which sought approval by the Board. It had been considered by the Finance & Policy Committee at their meeting on 18 March 2022. The budgeting process for the next year had been underway since October 2021, and the report followed on from a range of related reports considered in recent meetings which provided the Budget Outlook, a summary of the Scottish Budget, set the savings target, outlined draft budget proposals and the consultation process.

Decision

The Integration Joint Board –

1. Noted that the HSCP had developed a proposed balanced budget in line with the timetable.

2. Approved the proposed budget for 2022/23.

3. Approved the Budget Proposals / Savings Plan.

4. Noted Equality Impact Assessments had been completed and would be published on the website in respect of relevant savings proposals.

5. Noted the outcome of the public consultation process and noted that this had been considered in the amendments to the savings plan.

6. Approved the implementation of contract uplifts to ensure that all care staff received a minimum of £10.50 per hour from 1 April and noted that this was fully funded.

7. Noted the intention to repay the debt to Argyll and Bute Council early and establish a reserve for capital investment and service transformation as funding allowed.

8. Instructed the Chief Officer to accept Funding Offers from NHS Highland and Argyll and Bute Council and issue formal directions as detailed in the draft at appendix 5 to the submitted report.

(Reference: Report by Head of Finance and Transformation dated 30 March 2022,

submitted)

12. NATIONAL STRATEGY FOR COMMUNITY JUSTICE - ANALYSIS OF RESPONSES

The Board gave consideration to a report summarising the key outcomes of the consultation on the National Strategy for Community Justice.

Decision

The Integration Joint Board noted the content of the report.

(Reference: Report by Chief Social Work Officer dated 30 March 2022, submitted)

13. NATIONAL CARE SERVICE UPDATE - VERBAL

The Chief Officer provided a verbal update …….

Decision

The Integration Joint Board noted the verbal update from the Chief Officer in respect of the National Care Service.

(Reference: Verbal Update by Chief Officer)

14. INTEGRATION JOINT BOARD WORK PLAN - FOR NOTING

The Integration Joint Board workplan was before the Board for noting.

Decision

The Integration Joint Board noted the content of the workplan.

(Reference: Integration Joint Board Workplan dated 30 March 2022, submitted)

15. DATE OF NEXT MEETING

The date of the next meeting was noted as 25 May 2022.

Agenda Item 4a

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

MINUTES of MEETING of ARGYLL AND BUTE HSCP AUDIT AND RISK COMMITTEE held BY MICROSOFT TEAMS on TUESDAY, 12 APRIL 2022

Present: Councillor Sandy Taylor (Chair)

John Stevens
Councillor Kieron Green
Susan Ringwood

Attending: George Morrison, Depute Chief Officer, Argyll and Bute HSCP
James Gow, Head of Finance and Transformation, Argyll and Bute HSCP
Moira Weatherstone, Interim Chief Auditor, Argyll and Bute Council
Caroline Cherry, Head of Adult Services and Community Hospitals, Argyll and Bute HSCP
Charlotte Craig, Business Improvement Manager, Argyll and Bute HSCP
Geraldine Collier, People Partner
Fiona McCallum, Committee Services Officer, Argyll and Bute Council
Kyle McAulay, Senior Manager, Audit Scotland

1. APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting and introductions were made.

Apologies for absence were intimated on behalf of:

Sarah Compton Bishop, NHS Highland Non-Executive Board Member
Fiona Davies, Chief Officer, Argyll and Bute HSCP

2. DECLARATIONS OF INTEREST

There were no declarations of interest intimated.

3. MINUTES

The minute of the previous meeting of the Argyll and Bute HSCP Audit and Risk Committee, held on 15 February 2022, was approved as a correct record.

4. INTERNAL AUDIT UPDATE

Consideration was given to a report which provided an update on the progress made by the Council's Internal Audit Team to deliver the 2021/22 Internal Audit Plan.

A discussion also took place in light of a request made by the HR Team that the Workforce Planning Audit be re-scheduled to October 2022, following the completion of the IJB's Workforce Plan to be submitted to the Scottish Government in July 2022.

Decision

The Audit and Risk Committee:

1. reviewed and noted the progress on completion of the internal audit recommendations; and

2. agreed not to delay the timescale for completion of the Workforce Planning Audit which was due to be presented to this Committee in June 2022.

(Reference: Report by Interim Chief Internal Auditor dated 12 April 2022, submitted)

5. HSCP 2022/23 INTERNAL AUDIT PLAN

Consideration was given to a report presenting the final 2022/23 Argyll and Bute HSCP Internal Audit Plan to the Committee and providing an indicative audit plan for 2023/24 was considered.

Decision

The Audit and Risk Committee endorsed the 2022/23 HSCP Internal Audit Plan.

(Reference: Report by Interim Chief Internal Auditor dated 12 April 2022, submitted)

6. 2020/21 END OF YEAR ACCOUNTS TIMETABLE

The IJB is required to publish audited annual accounts each year. Normally these are to be signed by 30 September. In recent year this deadline has been extended due to the impact covid has had upon public sector administration.

A report outlining a timetable for preparation and audit of the 2022/23 accounts which aims to achieve final sign off by the IJB at its meeting scheduled for 23 November 2022 was considered.

Decision

The Audit and Risk Committee:

1. noted the proposed 2021/22 year end Accounts Timetable for the IJB;

2. noted that this aligned with the External Audit Plan and timetable;

3. noted that an amendment to the Audit and Risk Committee meeting schedule was required; and

4. agreed to delegate to the Head of Finance and Transformation, in consultation with the Chair of the Committee, to identify a suitable date for the Committee to meet and consider the 2021/22 Audited Accounts before these were presented to the IJB meeting scheduled for 23 November 2022.

(Reference: Report by Head of Finance and Transformation dated 12 April 2022, submitted)

7. EXTERNAL AUDIT ANNUAL AUDIT PLAN 2021/22

A report summarising the work plan for Audit Scotland's 2021/22 external audit of Argyll and Bute Integration Joint Board was considered.

Decision

The Audit and Risk Committee noted the contents of the External Audit Annual Audit plan 2021/22.

(Reference: Report by Audit Scotland dated March 2022, submitted)

8. NEW EXTERNAL AUDIT CONTRACT

The Accounts Commission has responsibility for the appointment of independent external auditors for IJBs. These appointments are normally made for a 5 year period.

Consideration was given to a report informing the Committee of the proposed appointment of Mazars as external auditor to Argyll and Bute IJB for financial years 2022/23 to 2026/27.

Decision

The Audit and Risk Committee noted:

1. the proposal to appoint Mazars as the External Auditor for financial years 2022/23 to 2026/27 following a tender exercise conducted by Audit Scotland; and

2. that no conflict of interest has been identified in relation to this appointment.

(Reference: Report by Head of Finance and Transformation dated 12 April 2022, submitted)

9. CONTINGENCY, RISK AND RESILIENCE GROUP

As a Category 1 Responder Argyll and Bute IJB is required to have plans in place to ensure it can respond appropriately to emergency situations, with partners, within Argyll and Bute. Additionally, the management of risk is a high priority for the IJB, its partners, and management.

Consideration was given to a report providing the Committee with details of the new Contingency, Risk and Resilience Group which has been established by the HSCP in order to strengthen and improve the governance relating to Contingency Planning and Risk Management.

Decision

The Audit and Risk Committee noted:

1. the establishment of the Contingency, Risk and Resilience Group;

2. the Terms of Reference of the Group; and

3. that it was intended that minutes of the Group would be provided to the Audit and Risk Committee.

(Reference: Report by Head of Finance and Transformation dated 12 April 2022, submitted)

10. AUDIT SCOTLAND - NHS IN SCOTLAND 2021

Consideration was given to a report providing the Committee with the Audit Scotland briefing on the NHS in Scotland, which summarised a wide range of strategic challenges facing the health service at present.

The report also brought to the Committee's attention, several other Audit Scotland publications which were of relevance to the HSCP, including reports on Local Government Finance, Climate Change, and Drug and Alcohol Services.

Decision

The Audit and Risk Committee noted that:

1. Audit Scotland have published a report on the NHS in Scotland 2021;

2. their report noted a series of severe challenges facing the NHS and highlighted increased demand, workforce challenges and increased waiting times;

3. Audit Scotland made a number of recommendations for Health Boards to implement and that the HSCP would produce an analysis of how it was addressing these; and

4. Audit Scotland have recently published a number of other reports which were of relevance.

(Reference: Report by Head of Finance and Transformation dated 12 April 2022, submitted)

11. DATE OF NEXT MEETING

The Audit and Risk Committee noted that the next meeting would be held on Tuesday 28 June 2022.

12. VALEDICTORY ADDRESS

The Chair thanked everyone for their contribution to this Committee and advised that it had been a joy to serve on and commended it to others.

He also wished Councillor Kieron Green every success at the forthcoming local government elections.

Councillor Green thanked the Chair for his contribution in leading this Committee and wished him well for the future.

Agenda Item 4b

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Argyll and Bute HSCP
Clinical and Care Governance Committee

28th April 2022 – 2pm
Via TEAMS

Minute

	Item	Action
1.0	**WELCOME AND APOLOGIES** **PRESENT** Sarah Compton Bishop (SCB) – IJB Chair (Chair) Catriona Dreghorn (CD) – Lead Midwife Claire Higgins (CH) - PA to Associate Nurse Director & Deputy Medical Director (note taker) Dr Nicola Schinaia (NS) - Associate Director of Public Health Dr Rebecca Helliwell (RH) - Deputy Medical Director Elizabeth Higgins (EM) – Associate Nurse Director Fiona Broderick (FB) – Staff Side Fiona Campbell (FC) – Clinical Governance Manager Fiona Thomson (FT), Associate Director of Pharmacist Jane Williams (JW) - Area Manager Bute Jean Boardman (JB) - Non-Executive Director, NHS Highland Jillian Torrens (JT) - Head of Adult Care - Mental Health, Learning Disabilities & Lifelong Conditions Julie Kidson (JK) - Child Health Manager CAMHS Kieron Green ((KG)– Elected Member & IJB Vice Chair Linda Currie (LC)– Associate AHP Director **APOLOGIES** Caroline Cherry (CC) - Head of Adult Services Charlotte Craig (CC)- Business Improvement Manager Cllr Sandy Taylor (ST) - IJB Member David Gibson (DG) - Head of Children & Families and Justice/CSWO Evan Beswick(EB) - Head of Primary Care Fiona Davies (FD) - Chief Officer	
2.0	**PREVIOUS MINUTES** The Minute of the meeting held on 24th February 2022, was approved as a correct record, subject to the following amendment- NS attendance to be double checked for accuracy and amended as appropriate.	

3.0	**ACTION LOG** Action 2 and 4 to be closed pending update. Update to be send via email to the Committee. Action 5 – timescale moved to October committee.	
4.0	**MATTERS ARISING** Nil	
EXCEPTION REPORTS BY OPERATIONAL AREA		
5.0	**(a) Adult Services - Older Adults and Community Hospitals** The Committee gave consideration to the Head of Service Exception Report which covers the following areas of responsibility; – All Adult Community based Services (except Mental Health/LD/PD) – All Hospitals – All Care Homes and Care at Home Services both provided and commissioned – Argyll and Bute Dementia Service SCB requested clarity on the meaning of **issue 1)** Complex Case Procedures/Processes. JW will request clarity from CC. Response to come to CH for circulation to the committee by email. KG queried **issue 2)** Dementia- access to specialist assessment beds. The committee was advised that an SLA with GGC is not in place as GGC declined after negotiation. RH advised that there has been a lot of discussion and many options explored to find appropriate solutions. KG suggested when doing future redesigns that issues should be scoped out before hand, RH agreed that this would be best practice. It was agreed that 'Dementia SLA with GGC, Pathways of Patient Care and Access/Delivery of Patient Care' should be added to the action log and updates brought to the Committee as appropriate. JB queried if the exception reports give enough info. Discussion to be picked up through the Framework review. SCB picked up on the issue relating to access STATMAN training figures. This is a known issue and it was agreed that there was room for improvement in this situation. EH updated the Committee regarding some positive feedback that has been received about the community dementia model. **(b) Children, Families and Justice** No reported submitted.	

	(c) Primary Care The Committee gave consideration to the Head of Service Exception Report which covers the following areas of responsibility; – Primary Care – General Practice – Dental – Community Pharmacy – Optometry – Vaccination – Community Treatment Rooms EH advised that the recruitment of CTAC and vaccination staff is ongoing. A Lead Nurse for Primary Care has been appointed and the manager role is being interviewed for next week. Band 7's have been appointed and interviews are planned for the other roles. SCB highlighted again the lack of STATMAN training figures. SCB requested more information on **Risk 2** – "There is a risk that a further two independent practices will terminate their contracts, which will result in service discontinuity". RH advised that if this was to happen the service would be handed back to the HSCP. Work is ongoing to support the independent practices and provide solutions. **(d) Mental Health, Addictions, Learning Disability, Autism, Transitions and Physical Disability** The Committee gave consideration to the Head of Service Exception Report which covers the following areas of responsibility; – Mental Health – Addictions – Learning Disability – Autism – Transitions – Physical Disability JT joined the Committee today as the new Head of Service for Mental Health, Addictions, Learning Disability, Autism, Transitions and Physical Disability. Report was noted by the committee.	
QUALITY AND EFFECTIVENESS OF CARE		
6.0	**(a) Infection Control** The Committee gave consideration to the Infection Control Report which presents an overview of infection prevention and control data and activities within Argyll & Bute HSCP.	

	The report covered the following areas; **1.** Surveillance of E.Coli, Clostriodiodes difficile infection (CDI), Staphylococcus aureus bacteraemia (including Meticillin resistant staphylococcus aureus (MRSA) and Staphylococcus aureus bacteraemia (SABs) **2.** Outbreaks in hospital settings **3.** Areas of challenge across the whole NHSH Board area EH presented the report and noted that the context for some of the figures presented was across the whole board area and that reporting on surveillance targets are carried out as a board. EH informed the Committee that successful recruitment of a Band 6 Trainee Infection, Prevention and Control Nurse as taken place. **(b) Complaints & Incidents - Top 3, Performance and Themes** The Committee gave consideration to the tabled report which presents data relating to health complaints and adverse events / incidents for review by the Committee.	
SAFETY AND EXPERIENCE		
7.0	**(a) CAMHS** JB have verbal update. The ask of the Committee today is to a reduce to standard operational risk level and move to reporting as and when appropriate. JB updated that there has been marked improvement in the oversight of governance issues of the service, resulting in a more resilient service. Recruitment is ongoing for many posts. Waiting times have significantly reduced There is an arrangement with Consultants in North Highland to obtain advice when required. The Committee agreed the service is in a much more stable position. The action can be removed from the Action Log and removed as a standing agenda item. In order to formally close JB has been asked to provide a short report including data to show the improvements. **(b) Patient Experience** A number of positive patient experience reflections was presented to and welcomed by the Committee. It was agreed that it was uplifting to hear positive stories.	
AOCB		
8.0	**AOCB** **(a) Framework Review**	

	RH presented a number of slides to update on the ongoing framework review. RH stressed the slides presented were a very early draft. RH emphasised the aim of the review and highlighted changes to the Committee agenda and structure. It was agreed a final draft is to be submitted to the July Committee. A revised version of the slides is to be sent to the Committee members within the next few weeks for comments. **(b) Level of Assurance Template** Template tabled for noting.	
FUTURE MEETINGS		
9.0	**2022 dates via Teams starting at 2pm (90mins)** – 28th July 2022 – 26th October 2022 – 2nd February 2023	

This page is intentionally left blank

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

MINUTES of MEETING of ARGYLL AND BUTE HSCP FINANCE AND POLICY COMMITTEE held BY MICROSOFT TEAMS on FRIDAY, 18 MARCH 2022

Present: Councillor Kieron Green (Chair)

Kenny Mathieson
Graham Bell
Elizabeth Higgins
Councillor Sandy Taylor

Attending: George Morrison, Depute Chief Officer, Argyll and Bute HSCP
James Gow, Head of Finance and Transformation, Argyll and Bute HSCP
Caroline Cherry, Head of Adult Services, Argyll and Bute HSCP
Stephen Whiston, Head of Strategic Planning and Performance, Argyll and Bute HSCP
Charlotte Craig, Business Improvement Manager, Argyll and Bute HSCP
Abbie MacIver, Accountant, Argyll and Bute Council
Fiona Broderick, Staffside, Argyll and Bute HSCP
Lynsey Innis, Senior Committee Assistant, Argyll and Bute Council

1. APOLOGIES FOR ABSENCE

Apologies for absence were intimated on behalf of:-

Sarah Compton-Bishop, Non-executive Board Member
Fiona Davies, Chief Officer, Argyll and Bute HSCP
Kevin McIntosh, Staffside, Argyll and Bute Council

2. DECLARATIONS OF INTEREST

There were no declarations of interest intimated.

3. MINUTES

The minute of the previous meeting of the Finance and Policy Committee, held on 25 February 2022, was approved as a correct record.

4. BUDGET MONITORING - 11 MONTHS TO 28 FEBRUARY 2022

The Committee gave consideration to a report which provided a summary of the financial position of the Health and Social Care Partnership for the 11 months to 28 February 2022 and an updated financial forecast for the year. The report also provided an update on the savings programme and additional in-year funding allocation to help manage winter pressures.

Decision

The Finance and Policy Committee:-

1. Noted that the forecast outturn position is an underspend of £250k.

2. Noted the additional funding allocation by the Scottish Government and the terms associated with it (appendix 4).

3. Noted that unspent funds will be carried forward as earmarked reserves.

4. Noted that the IJB now expects to repay debt owed to Argyll and Bute Council early, estimated at an additional payment totalling £1.8m.

5. Noted that there is a year to date underspend of £224k at 28 February 2022.

(Reference: Report by Head of Finance and Transformation, dated 18 March 2022, submitted)

5. BUDGET 2022/23

The Committee gave consideration to a report which provided a proposed budget and associated savings plan for 2022/23 for approval by the IJB on 30 March 2022. The report followed on from a range of related reports considered in recent meetings which provided the Budget Outlook, a summary of the Scottish Budget, set the savings target, outlined draft budget proposals and the consultation process and focused primarily on the development of a budget for the HSCP for 2022/23 that was based on the mid-range scenario outlined in previous planning documents.

Decision

The Finance and Policy Committee:-

1. Reviewed the proposed balanced budget for 2022/23 prior to its consideration by the IJB on 30 March 2022.

2. Noted the outcome of the public consultation process and that this had been considered in the amendments to the savings plan.

3. Endorsed the reduced savings target and programme, as assumed in the budget.

4. Noted that the HSCP will implement contract uplifts to ensure that all care staff receive a minimum of £10.50 per hour from 1 April and that this is fully funded.

5. Noted and endorsed the intention to repay the debt to Argyll and Bute Council early and establish a reserve for capital investment and service transformation as funding allows.

(Reference: Report by Head of Finance and Transformation, dated 18 March 2022, submitted)

6. SAVINGS PROGRESS UPDATE - CORPORATE

Consideration was given to a report which provided a summary of the Corporate Services savings position as at 31 January 2022, the current challenges to delivery of the savings and planned actions to progress the outstanding savings.

Decision

The Finance and Policy Committee:-

1. Noted the progress in respect of the 2021/22 Corporate Savings Programme and savings to be carried into 2022/23 as at 31 January 2022.

2. Noted the challenges to achieving savings in 2021/22.

3. Noted the planned Corporate Savings Programme for 2022/23.

(Reference: Report by Head of Strategic Planning, Performance and Technology, dated 18 March 2022, submitted)

7. CHILDREN AND FAMILIES UPDATE

Consideration was given to a report which summarised the progress to date of the Children and Families savings programme and its approach to longer term transformation.

Decision

The Finance and Policy Committee:-

1. Considered the progress the Service is making towards meeting its approved savings targets.

2. Noted the Service's approach to long term transformation.

(Reference: Report by Head of Children and Families, dated 18 March 2022, submitted)

8. DATE OF NEXT MEETING

The Finance and Policy Committee noted that the date of the next meeting was scheduled to take place on Friday, 22 April 2022.

This page is intentionally left blank

Agenda Item 4d

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

MINUTES of MEETING of ARGYLL AND BUTE HSCP FINANCE AND POLICY COMMITTEE held BY MICROSOFT TEAMS on FRIDAY, 29 APRIL 2022

Present: Councillor Kieron Green (Chair)

Sarah Compton-Bishop
Kenny Matheson
Graham Bell

Attending: Fiona Davies, Chief Officer, Argyll and Bute HSCP
George Morrison, Depute Chief Officer, Argyll and Bute HSCP
James Gow, Head of Finance and Transformation, Argyll and Bute HSCP
Jillian Torrens, Head of Adult Services
Geraldine Collier, HR People Partner, Argyll and Bute HSCP
Charlotte Craig, Business Improvement Manager, Argyll and Bute HSCP
Lorna Jordan, Senior Accountant, Argyll and Bute Council
Lynsey Innis, Senior Committee Assistant, Argyll and Bute Council

1. APOLOGIES FOR ABSENCE

The Chair extended a warm welcome to Jillian Torrens who had recently taken up the post of Head of Adult Services.

Apologies for absence were intimated on behalf of:-

Councillor Sandy Taylor
Elizabeth Higgins, Professional Advisory Group Representative
Fiona Broderick, Staffside, Argyll and Bute HSCP
Kevin McIntosh, Staffside, Argyll and Bute Council

2. DECLARATIONS OF INTEREST

There were no declarations of interest intimated.

3. MINUTES

The minute of the previous meeting of the Finance and Policy Committee, held on 18 March 2022, was approved as a correct record.

4. FINAL SAVINGS POSITION 2021-22

The Committee gave consideration to a report which provided a summary of performance in delivering the 2021/22 savings programme and confirmation of the savings projects that are being carried forward into 2022/23.

The Head of Finance and Transformation provided a short verbal update on the absence of a budget monitoring report due to the timescales involved with the year-end requirements. He advised that due to being in a slightly better position than anticipated, it had been possible to repay the debt to Argyll and Bute Council, as at 31 March 2022. Mr Gow highlighted that there would be a small balance to carry forward as a general reserve for use within the next financial year and advised that a paper confirming this position would be provided to the next meeting of the Committee.

Decision

The Finance and Policy Committee:-

1. Noted the final position in respect of the 2021/22 Savings Programme and the delivery of £8.2m of savings in total.

2. Noted that £5.8m in recurring savings were declared during that year.

3. Noted that future reporting on savings delivery will be based upon the new savings programme provided as Appendix 4.

(Reference: Report by Head of Finance and Transformation, dated 29 April 2022, submitted)

5. FINANCIAL RISKS 2022-23

Consideration was given to a report which provided an update on the perceived financial risks facing the HSCP, which could have an impact upon financial performance during 2022/23.

Decision

The Finance and Policy Committee:-

1. Considered the 2022/23 financial risks identified for the HSCP as at 30 March 2022 and noted the mitigations.

2. Noted that financial risks will be reviewed and reported every two months.

(Reference: Report by Head of Finance and Transformation, dated 29 April 2022, submitted)

6. CARE/NURSING HOME PROVISION - KINTYRE

The Committee gave consideration to a report which outlined the current situation with the Kintyre Care Centre and its owners HC-One, and provided details of how the HSCP is responding, in partnership with Argyll and Bute Council, and provided

an initial opportunity for Members to discuss and consider the implications and options available.

Decision

The Finance and Policy Committee:-

1. Noted that a joint project with Argyll and Bute Council is underway in respect of Nursing Care Home Provision in Kintyre/Campbeltown.

2. Noted that decisions with service capacity, financial and HR implications are expected to be required in the coming months.

(Reference: Report by Head of Finance and Transformation and Head of Adult Services, dated 29 April 2022, submitted)

7. PUBLIC SECTOR DUTIES

Having noted that there is potential for the public duties of the IJB to increase on the basis of response from public consultation and amendment to legislation and the need to be alert to any potential requirement for policy impact or development, the Committee gave consideration to a report which provided a detailed outline of the current public sector duties.

Decision

The Finance and Policy Committee:-

1. Referenced current public sector duties.

2. Noted the prospective training.

(Reference: Report by Business Improvement Manager, dated 29 April 2022, submitted)

8. CONSULTATION TRACKER

Having noted that the Scottish Government is consulting widely on many areas which directly or indirectly relate to legislation, the role of public bodies or the shaping of policy and national outcomes, the Committee gave consideration to a report which presented a consultation tracker designed to maintain an awareness of environment and the ability to respond and influence for remote and island communities, that will be presented to Committee on a regular basis.

Decision

The Finance and Policy Committee:-

1. Noted the consultation tracker.

2. Considered and agreed the proposed approach.

(Reference: Report by Business Improvement Manager, dated 29 April 2022, submitted)

9. DATE OF NEXT MEETING

The Finance and Policy Committee noted that the next meeting was scheduled to take place on Friday, 27 May 2022.

Having noted that this was the last meeting of the Finance and Policy Committee in this term of the Council, Councillor Green took the opportunity to thank the Committee and officers for the support they have provided to him during his term as Chair.

A&B HSCP | Transforming Together
Argyll & Bute Health & Social Care Partnership

MINUTES of SPECIAL MEETING of ARGYLL AND BUTE HSCP STRATEGIC PLANNING GROUP held BY MICROSOFT TEAMS on WEDNESDAY, 27 APRIL 2022

Present: Jean Boardman, Non-Executive Director of Highland NHS Board & Member of the IJB (Chair)
Kristin Gillies, Senior Planning Manager
Alison McGrory, Health Improvement Principal
Charlotte Craig, Business Improvement Manager
Liz Higgins, Associate Nurse Director
Fiona Broderick, Staff Side Representative
Fiona Davies, Chief Officer
John Stevens, Chair of North Argyll Carers Service
Julie Hodges, Independent Care Providers Sector Leader
Councillor Kieron Green, Vice Chair of the IJB
Alison Ryan, Service Planning Manager
Douglas Whyte, Area Housing Manager
Duncan Martin, Public Representative
Fiona Thomson, Associate Director of Pharmacy
Gillian McCready, Service Improvement Officer Older Adults
James Gow, Head of Finance and Transformation
Jillian Torrens, Head of Adult Services, Mental Health, Learning Disability and Lifelong Learning
Sarah Griffin, Public Health Intelligence Specialist
Rebecca Helliwell, GP and Rural Practitioner, Depute Medical Director
Emma Mason, Planning Secretary (minutes)

1. WELCOME, INTRODUCTIONS AND APOLOGIES

The Chair, Jean Boardman, welcomed everyone to the meeting and general introductions were made.

Apologies for absence were intimated on behalf of Stephen Whiston; Caroline Cherry; George Morrison; Allan Murphy; Donald Watt; David Forshaw; Kirsty MacKenzie; Kevin McIntosh and Fiona Coffield.

2. JOINT STRATEGIC PLAN 2022-2025

The Senior Service Planning Manager, Kristin Gillies gave a presentation providing an update on the Joint Strategic Plan for 2022 – 2025, along with Public Health Intelligence Specialist, Sarah Griffin describing the Joint Strategic Needs Assessment and Engagement work, which was before the group for approval, before being presented to the IJB at its meeting on 25 May 2022. Kristin expressed her thanks to the team for the production of the report. She advised the plan will go to an external publisher for accessibility and publishing requirements. The planning team

will develop a one page plan and a suggestion was made for the performance team to develop a one page progress update in a year's time. This suggestion will be considered to see if it will be feasible.

The group welcomed the one page plan and the suggestion of a one page progress update. The group discussed the Joint Strategic Plan positively and fedback some inclusions and changes to be made. This was noted by the planning team to implement the feedback within the plan. The group requested a session on performance measurement of the Joint Strategic Plan. It was agreed that this will be on the agenda for a future SPG meeting.

Decision

The Strategic Planning Group:-

1. noted the presentation; and approved the Joint Strategic Plan 2022 – 2025 on the understanding that the discussed inclusions and changes are implemented.

2. noted the development of the one page Strategic Plan and the possibility of a one page Progress update in a year's time.

3. noted session requested on performance measurement of the Joint Strategic Plan at a future SPG meeting.

(Reference: Presentation by Senior Service Planning Manager and Joint Strategic Plan)

3. DATE OF NEXT MEETING

The group noted that the next meeting would take place on Thursday, 9 June 2022.

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Integration Joint Board **Agenda item: 5**

Date of Meeting: **25 May 2022**

Title of Report: **Chief Officer Report**

Presented by: **Fiona Davies, Chief Officer**

The Integration Joint Board is asked to:

- Note the following report from the Chief Officer

In my Chief Officers report it gives me great pleasure to highlight staff achievements and where we work across the partnership to think about how we do things in future and learn a little from each of our different disciplines.

It's also an opportunity for me to communicate directly with the public in Argyll & Bute, summarising some of the opportunities in developing health and social care services for the future.

Strategic Plan 2022-2025

In this meeting of the Board we present the Strategic Plan of the Integration Joint Board which will set out our course for the next three years based on our national guidance, our population and in consultation with our communities. Together with the Joint Commissioning Plan presented at the March 2022 IJB this will provide the direction and support how we plan and deliver services.

National Care Service

The National Care Service is likely to be the biggest change in our health and social care services since the National Health Service and is a hugely exciting time in terms of our ambitions for quality services in our urban, remote and island communities. I'll be thinking a lot about how I can best communicate this through the Chief Officers report in future and through our local structures now we are moving into a different phase of the pandemic.

Deputy Chief Officer and Associate Director of Public Health

Our Deputy Chief Officer George Morrison will be retiring this month after 42 years of public service. Coming into the Chief Officers role George has been invaluable both in his experience and as a supportive colleague. He will be much missed.

Our esteemed colleague Dr Nicola Schinaia will also be moving to another post within NHS Highland. Nicola has provided his epidemiological expertise guiding us through the pandemic but is also known for his kindness and support to colleagues.

We will be recruiting initially on a temporary basis to the Associate Director of Public Health for a three month period prior to permanent recruitment and recruiting on a permanent basis for the Depute Chief Officer through the standard external process.

COVID-19 Update

The Scottish Government recently implemented significant changes to COVID-19 guidance and all remaining rules and restrictions are no longer part of legislation.

We would however remind the public that COVID-19 has not gone away and we would encourage everyone to help protect themselves and others by following the most recent public health advice which can be accessed at www.nhsinform.scot

Up to date information on COVID-19 in Argyll & Bute is available in the Associate Director of Public Health's Report to the IJB.

We would like to thank everyone across Argyll and Bute for their commitment over the last two years to following the appropriate guidance and keeping their communities as safe as possible.

I'd like to offer my thanks to our staff teams for their continued commitment to delivering care in our hospitals and communities.

Rethinking Remote Conference

I recently attended the Rethinking Remote Conference which was held at the end of April. This conference provides an opportunity for health and social care professionals to share information, ideas, research, and solutions and provides a showcase for the sharing of practical initiatives that are already making a difference to the health and wellbeing of remote and rural communities.

Lorn & Islands Hospital Macmillan Day Bed Unit

The official opening of the Lorn & Islands Hospital Macmillan Day Bed Unit was held on Friday 29 April and we would like to thank everyone who came along on the day as well as our staff and our colleagues from Macmillan who have been involved in the overall project.

This welcome investment in the Day Bed Unit will build on the support and treatment for those living with cancer and will mean that additional treatments can be provided locally which will reduce the number of patients needing to travel further afield to get the treatment that they need.

The refurbishment has also created a more spacious and comfortable treatment area for patients and staff with a warm and welcoming reception and waiting area for patients and their families as well as a private area for consultations.

Midwifery Practice Education Facilitator

Charlotte Morbey has recently taken up the role as Midwifery Practice Education Facilitator for the HSCP. As part of her role she links in with a range of higher education institutions and works closely with Midwife Supervisors to help midwifery students gain invaluable experience while on placement.

During their placements the students are involved in a variety of different areas of midwifery including antenatal and postnatal visits, pregnancy screening, hypnobirthing support and perinatal mental health support.

The feedback from the students on placement has been very positive and they have been really pleased with the welcome and support they received locally from staff and delighted that they are able to put into practice the skills they have been learning on their course.

Argyll and Bute Council Transition and Induction Plan

Senior HSCP Managers, including the Chief Officer, will be participating with colleagues in Argyll and Bute Council in the Council's Transition and Induction Plan for elected members that will be implemented following the local authority elections on 5 May.

NHS Scotland Event 2022

The annual NHS Scotland Event will take place this year from 21-22 June in Aberdeen. This Event provides an opportunity for people working in health and social care to come together to discuss the challenges, to share best practice and innovative approaches to delivering the highest quality of care.

This year's Event will focus on the journey ahead to recover from the effects and challenges of the COVID-19 Pandemic and will look at how we address these challenges by focusing on our priorities and building on our successes.

One element of the Event every year is the submission of posters from staff highlighting aspects of work they are undertaking as part of their role. A number of these posters are shortlisted for showcasing at the event and on behalf of Argyll & Bute I will be participating in the judging.

This page is intentionally left blank

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Date of Meeting: 25 May 2022

Title of Report: Appointment of Elected members to the IJB and representation on the IJB Committee Structure

Presented by: Douglas Hendry

The Board is asked to:

- Note changes in the membership of the IJB and impact on the representation throughout the Committee structure.
- Appoint two members to the IJB Audit and Risk Committee
- Appoint two members to the IJB Clinical and Care Governance Committee
- Appoint two members to the IJB Finance and Policy Committee
- Appoint one member to the IJB Strategic Planning Group
- Approve the updated Terms of Reference which reflects member job titles.

1. EXECUTIVE SUMMARY

Following the Local Government Elections and subsequent changes to elected member representation on the IJB there is a requirement to appoint new members to ensure representation across the committee structure.

Each committee/group requires two elected members either in the chair or vice chair role of the committees and as a member of the Strategic Planning Group.

The chair/vice chair of the Finance and Policy Committee should not be the chair/vice chair of the Audit and Risk Committee

The Terms of Reference have been updated to reflect professional advisory job titles but there is no other material change.

2. INTRODUCTION

This report outlines the requirement for the IJB to make new appointments to each of the three committees and to the Strategic Planning Group.

3. DETAIL OF REPORT

3.1 The Terms of reference indicate the current requirement of members for the committee structures, this also includes professional advisors and wider partners on the Strategic Planning Group.

The tables below indicate the required IJB membership on committees and current gaps.

Two elected members are required for each committee and one elected member at the Strategic Planning Group.

One elected member on each committee should be the chair or vice chair with no conflict between the Finance and Policy and Audit and Risk Committees.

Clinical & Care Governance Committee		
Role	**Current**	**Membership**
Chair IJB Member (Council or NHS)	Sarah Compton-Bishop	Member
Vice Chair IJB Member (Council or NHS)		Member
IJB Member	Jean Boardman	Member
IJB Member		Member

Audit & Risk Committee		
Role	**Current**	**Membership**
Chair IJB Member		Member
Vice Chair IJB Member	Susan Ringwood	Member
IJB Member		Member
IJB Member	Sarah Compton Bishop	Member
IJB Member	John Stevens	Member
IJB Member		Member

Finance & Policy Committee		
Role	**Current**	**Membership**
Chair		Member
Vice Chair	Sarah Compton-Bishop	Member
IJB Member		Member
IJB Member		Member
IJB Member	Graham Bell	Member
IJB Member	Kenny Matheson	Member

SPG Role	**Current Member**	**Role**
Co chair	Stephen Whiston	Head of Strategic Planning and Performance
Co chair (IJB member)	Jean Boardman	Non Executive Director NHS Highland
Chief Officer	Fiona Davies	Chief Officer Health and Social Care
IJB Member NHS	Sarah Compton-Bishop	Chair, Integrated Joint Board

IJB Member Council		

Other than changes to the elected member representation on these committees the membership is assumed to be unaffected and will be reviewed in line with the requirements of the Terms of Reference.

The job titles of the professional advisory have been updated in the attached Terms of Reference to avoid confusion and this is noted in the document control, we would seek the IJB to approve this with updated membership.

4. RELEVANT DATA AND INDICATORS

Not applicable

5. CONTRIBUTION TO STRATEGIC PRIORITIES

The IJB require to have appropriate arrangements in place to provide robust governance and partner representation on the IJB.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact

None

6.2 Staff Governance

None

6.3 Clinical Governance

Appointment of appropriate membership to ensure oversight for the safe and effective delivery of care, professional standards and practice.

7. PROFESSIONAL ADVISORY

None required specifically for this report

8. EQUALITY & DIVERSITY IMPLICATIONS

The governance structure of the IJB supports scrutiny of equalities issues.

9. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

None.

10. RISK ASSESSMENT

Risk of non-compliance with the Terms of Reference and agreed representation on Committees if new elected members are not nominated.

11. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

None for this report.

12. CONCLUSIONS

The IJB are required to nominate new elected member representatives to the IJB Committees and Strategic Planning Group to replace the elected members no longer part of the Integration Joint Board. These arrangements would be effective immediately and within the Terms of Reference.

13. DIRECTIONS

Directions required to Council, NHS Board or both.	**Directions to:**	tick
	No Directions required	x
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

REPORT AUTHOR AND CONTACT

Author Name Charlotte Craig
Email charlotte.craig@argyll-bute.gov.uk.

A&B HSCP Transforming Together

Argyll & Bute Health & Social Care Partnership

Argyll & Bute Integration Joint Board Committee Terms of Reference

Document control

Title	IJB Committee Terms of Reference
Author	Charlotte Craig
Creation date	May 2020
Date of version	May 2022

Version history

Version	**Comments**
V2.0	Approved at May IJB
V2.1	Updated CSWO role and reflect staff changes
V2.2	Update to the general provisions reflect the committee/group requirement to report annually to the IJB Updated Terms of Reference for the Strategic Planning Group
V2.3	Update to job titles of professional advisory, members and addition of a cover page.

Current Committee Membership

Audit & Risk Committee		
Role	**Current**	**Membership**
Chair IJB Member		Member
Vice Chair IJB Member	Susan Ringwood	Member
IJB Member		Member
IJB Member	Sarah Compton Bishop	Member
IJB Member	John Stevens	Member
IJB Member	Vacant	Member
Chief Officer	Fiona Davies	Attendee (required)
Chief Finance Officer	James Gow	Attendee (required)
External Auditor		Attendee (required)
Internal Auditor	Argyll & Bute Council	Attendee (required)
Officers attend as required		Attendee

Clinical & Care Governance Committee		
Role	**Current**	**Membership**
Chair IJB Member (Council or NHS)	Sarah Compton-Bishop	Member
Vice Chair IJB Member (Council or NHS)		Member
IJB Member	Jean Boardman	Member
IJB Member		Member
Chief Officer	Fiona Davies	Member
Deputy Medical Director	Dr Rebecca Helliwell	Member
Associate Director Public Health	Dr Nicola Schinaia	Member
Head of Primary Care	Evan Beswick	Attendee (required)
Associate Director of Nursing	Elizabeth Higgins	Member
Head of Children & Families and Justice/CSWO	David Gibson	Member
Associate Director of AHP	Linda Currie	Attendee (required)
Associate Director of Pharmacy	Fiona Thomson	Attendee (required)
Head(s) of Adult Services	Caroline Cherry	Attendee (required)
Head(s) of Adult Services	Jillian Torrens	Attendee (required)
Clinical Governance Manager	Fiona Campbell	Attendee (required)
Staffside Representative	Fiona Broderick/Kevin McIntosh	Member
Staff attend as required		Attendee
Public Representative		

Finance & Policy Committee		
Role	**Current**	**Membership**
Chair		Member
Vice Chair	Sarah Compton-Bishop	Member
IJB Member	Graham Bell	Member
IJB Member	Kenny Matheson	Member
IJB Member		Member
IJB Member		Member
Professional Advisory Group Representative	Elizabeth Higgins	Member
Chief Officer	Fiona Davies	Attendee (required)
Chief Finance Officer	James Gow	Attendee (required)
Staffside	Fiona Broderick/Kevin McIntosh	Attendee (required)
Officers attend as directed		Attendee

SPG Role	**Current Member**	**Role**
Co chair	Stephen Whiston	Head of Strategic Planning and Performance
Co chair (IJB member)	Jean Boardman	Non Executive Director NHS Highland
Chief Officer	Fiona Davies	Chief Officer Health and Social Care
IJB Member NHS	Sarah Compton-Bishop	Chair, Integrated Joint Board
IJB Member Council		Vice - Chair, Integrated Joint Board
Health & Social Care Member	Dr Rebecca Helliwell	Deputy Medical Director
Health & Social Care Member	David Gibson	Head of Service, Children & Families and Justice/CSWO
Health & Social Care Member	Caroline Cherry	Head of Adult Services
Health & Social Care Member	Jillian Torrens	Head of Adult Services
Health & Social Care Member	Elizabeth Higgins	Associate Director of Nursing/Professional Lead Rep
Public Health	Alison McGrory	Public Health Principal
Housing	Alastair MacGregor	Director, ACHA
Housing	Allan Murphy	Director, Dunbritton Housing
Housing(LA)	Douglas Whyte	Strategic Housing Manager A&B Council
Third Sector	Takki Sulaiman	CEO, Argyll TSI
Third Sector	Niall Kieron	Divisional General Manager, Marie Curie, Scotland
Independent sector	Margaret McGowan/Julie Hodges	Independent Sector Representatives, Scottish Care
Service User	Duncan Martin	

Service User	Michael Roberts	
Carers	Kirsty McKenzie	Carers' Act Implementation Officer
Carers Representatives (x2)	Vacant	Carers Representatives
Finance	James Gow	Head of Finance and Transformation
Planning	Kristin Gillies	Senior Service Planning Manager HSCP
Planning	Alison Ryan	Service Planning Manager HSCP
Carers		Chair of the Chairs of the Carers Centres

Locality Planning Groups (x4)		
Role	**Current**	**Membership**
Chair	Area Manager	Member
Co-Chair	Other than HSCP staff	Member
Community Members (2)	Various based on Locality	Member
Carers (2)	To be recruited	Member
Third Sector	Various based on Locality	Member
Independent Sector	Various based on Locality	Member
Primary Care	Various based on Locality	Member
Housing	Various based on Locality	Member
Education	Various based on Locality	Member
Community Council (2)	To be recruited	Additional Members Argyll & Bute (not statutory)
Elected members	Various based on Locality	Additional Members Argyll & Bute (not statutory)

IJB Membership

The role and constitution of IJB is established through legislation. The voting membership is:

a. NHS Highland : 4 members of the NHS Highland Health Board
b. Council: 4 Elected members of the Council nominated by the Council

The term of office of the Chair and the Vice Chair will be a period of two years. NHS Highland and the Council will appoint one of their four representatives to act as Chair/Vice Chair on a two year rotating basis.
The Chief Officer and Chief Financial Officer shall attend Committee meetings in their capacity of advisers and not as members of the Committees.
The decision making structure whereby the committees of the IJB have Terms of Reference agreed by the IJB include the Clinical and Care Governance Committee, Audit and Risk Committee and Finance and Policy Committee.
The act makes provision for a Strategic Planning Group for the development and delivery of the Strategic Plan. Argyll & Bute IJB have approved a Locality Planning Group model to engage on local planning.

1.1. Clinical and Care Governance Committee Membership

The Committee will consist of not less than 6 members, being IJB representatives, officers, stakeholders and professional advisers. The IJB shall appoint IJB representatives to the Committee, appropriate officer representation will be co-ordinated by the Chief Officer.

Role	Membership
Chair IJB Member (Council or NHS)	Member
Vice Chair IJB Member (Council or NHS)	Member
IJB Member	Member
IJB Member	Member
Chief Officer	Member
Deputy Medical Director	Member
Associate Director Public Health	Member
Associate Clinical Dental Director	Member
Associate Director of Nursing	Member
Head of Children & Families & Justice/CSWO	Member
Lead AHP	Member
Lead Pharmacist	Member
Head(s) of Adult Services	Member

Head(s) of Adult Services	Member
Clinical Governance Manager	Attendee (required)
Staffside Representative	Member
Locality Staff attend as required	Attendee
Carer/public representatives	Member

1.2. Audit and Risk Committee Membership

Audit and Risk Committee consists of six members of the IJB (minimum two voting members - one from NHS Highland and one from the Council)
The Chair and Vice-Chair of the IJB Audit and Risk Committee will be appointed by the IJB for a two-year term. Neither may be Chair or Vice-Chair of the IJB.
Other persons may participate in meetings by invitation of the Chair.

Role	**Membership**
Chair IJB Member	Member
Vice Chair IJB Member	Member
IJB Member	Member
IJB Member	Member
IJB Member	Member
IJB Member	Member
Chief Officer	Attendee (required)
Chief Finance Officer	Attendee (required)
External Auditor	Attendee (required)
Internal Auditor	Attendee (required)
Officers attend as required	Attendee

1.3. Finance and Policy Committee Membership

The Committee will consist of not less than 8 members, being IJB representatives, officers, stakeholders and professional advisers. The IJB shall appoint IJB representatives to the Committee, appropriate officer representation will be co-ordinated by the Chief Officer.

Role	**Membership**
Chair, Integrated Joint Board	Member
Vice - Chair, Integrated Joint Board	Member
IJB Member	Member
IJB Member	Member
IJB Member	Member
IJB Member	Member
Professional Advisory Group Representative	Member

Chief Officer	Attendee (required)
Chief Finance Officer	Attendee (required)
Staffside	Attendee (required)
Officers attend as directed	Attendee

1.4. Strategic Planning Group Membership

The Strategic Planning Group is established according to Section 32 of the Public Bodies (Joint Working) (Scotland) Act 2014 and will report to the full IJB Board as required.

Role	**Membership**
Chair	Member
Co-Chair (IJB Member)	Member
IJB Member (carers)	Member
IJB Member	Member
IJB Member	Member
Chief Officer	Member
Chief Financial Officer	Member
Deputy Medical Director	Member
Associate Director Public Health	Member
Head of Primary Care	Member
Associate Director of Nursing	Member
Head of Children & Families & Justice/CSWO	Member
Associate Director of AHP	Member
Lead Pharmacist	Member
Head(s) of Adult Services	Member
Staffside Representative	Member
Senior Service Planning Manager	Member
Housing (Council and other)	Member
Third Sector (TSI CEO + 1)	Member
Carers Act Implementation Officer	Member
Independent Sector	Member
Officers attend as required	Attendee

Locality Planning Groups Membership

Locality Planning Groups (x4)		
Role	**Current**	**Membership**
Chair	• Area Manager	• Member
Co-Chair	• Other than HSCP staff	• Member
Community Members (2)	• Various based on Locality	• Member
Carers (2)	• To be recruited	• Member
Third Sector	• Various based on Locality	• Member
Independent Sector	• Various based on Locality	• Member
Primary Care	• Various based on Locality	• Member
Housing	• Various based on Locality	• Member
Education	• Various based on Locality	• Member
Community Council (2)	• To be recruited	• Additional Members Argyll & Bute (not statutory)
Elected members	• Various based on Locality	• Additional Members Argyll & Bute (not statutory)

2. GENERAL PROVISIONS REGULATING MEMBERSHIP

Members of the IJB subscribe to and comply with the Standing Orders and Code of Conduct and the appointed Standards Officer is responsible for advising and guiding members of the Board on issues of conduct and propriety. A register of interests is in place for all Board members and senior officers.
The IJB operates within an established procedural framework. The roles and responsibilities of Board members and officers are defined within the Integration Scheme, Standing Orders and Financial Regulations; these are subject to regular review.

The Committees will report directly to IJB regularly and annually on a formal basis and will provide clear, robust, accurate and timely information on the quality of service performance.

2.1. Appointments

The IJB will make all appointments to the Committees including the appointment of the Chair and Vice-Chair of the Committees.

2.2. Chair and Vice-Chair

2.2.1. The Chair and Vice-Chair of the Committees will be members of the IJB appointed from those members appointed to the Committees;

2.2.2. The appointment of Chair and Vice-Chair will be for a two year term.

2.3. Quorum

2.3.1. Three members of the Audit & Risk Committee and the Finance & Policy Committee, one from each partner body and one other, shall constitute a quorum, with at least one of the members being Chair or Vice-Chair.

2.3.2. The Clinical & Governance Committee and Strategic Planning Group will require one third of their membership with at least one member from each partner body.

2.3.3. Ordinary Committee members (i.e. other than the Chair/Vice-Chair) may nominate deputies to attend meetings to ensure meetings are quorate, this will only be permitted with prior agreement by the Chair.

2.3.4. No business shall be transacted unless this minimum number of members is present. For the purposes of determining whether a meeting is quorate, members attending by video or audio link will be determined to be in attendance.

2.4. Frequency of Meetings

2.4.1. The Committees will meet on a frequency to be determined by IJB, on dates to be specified in an annual programme of meetings, with meetings normally held at least quarterly in each financial year at a place and time as determined by each Committee.

2.4.2. The Chair of each Committee may at any time convene additional meetings or increase frequency of meetings to consider business, which may require urgent consideration.

2.5. In Attendance

2.5.1 Agendas will follow standard template which will cover all elements of the Committee's framework.

2.6. Sub-groups

2.6.1. The Committees may at their discretion set up working groups for specific tasks. Membership of working groups will be open to anyone whom the Committees consider will be able to assist in the task assigned. The working groups will report their findings and any recommendations to each Committee.

CLINICAL AND CARE GOVERNANCE COMMITTEE TERMS OF REFERENCE

1. REMIT

The Committee's framework will encompass the following responsibilities as detailed in paragraph 5.8 of the Integration Scheme.

Each of the four elements, listed below, will be

1.1. underpinned by mechanisms to measure quality, clinical and service effectiveness and sustainability. They will be compliant with statutory, legal and policy obligations strongly underpinned by human rights values and social justice. Service delivery will be evidence-based, underpinned by robust mechanisms to integrate professional education, research and development.

1.2. Measure the quality of integrated service delivery by measuring delivery of personal outcomes and seeking feedback from service users and/or carers;

1.3. Professional regulation and workforce development;

1.4. Information governance

1.5. Safety of integrated service delivery and personal outcomes and quality of registered services

The Committee will ensure that quality monitoring and governance arrangements are in place for safe and effective health and social care service delivery in Argyll and Bute. This will include the following:-

1.6 Compliance with professional codes, legislation, standards, guidance. Systems and processes to ensure a workforce with the appropriate knowledge and skills to meet the needs of the local population.

1.7 Effective internal systems that provide and publish clear, robust, accurate and timely information on the quality of service performance.

1.8 Systems to support the structured, systematic monitoring, assessment and management of risk's-ordinated risk management, complaints, feedback and adverse events/incident system, ensuring that this focuses on learning, assurance and improvement.

1.9 Improvement and learning in areas of challenge or risk that are identified through local governance mechanisms and external scrutiny.

1.10 Mechanisms that encourage effective and open engagement with staff on the design, delivery, monitoring and improvement of the quality of care and services.

1.11 Planned and strategic approaches to learning, improvement, innovation and development, supporting an effective organisational learning culture.

1.12 To provide assurance to the Integrated Joint Board that systems, processes and procedures are in place and are delivering effective clinical and care governance throughout Argyll and Bute.

This will include the following:

1.13 To develop and monitor clinical and care assurance systems to regulate the quality and safety of health and care services

1.14 To monitor implementation of Care Inspectorate and NHS Healthcare Improvement Scotland clinical standards and other external review body standards and guidelines – such as Mental Welfare Commission, SPSO etc.

1.15 To oversee self-evaluation and preparation for joint inspections and to oversee local implementation of recommendations following review

1.16 To oversee the review all incidents to identify trends, to take appropriate action and disseminate lessons learnt across Argyll and Bute (and NHS Highland where appropriate)

1.17 To oversee the review of all feedback, including complaints and compliments, to ensure proper management, identify trends and disseminate lessons learnt across Argyll and Bute (and NHS Highland where appropriate)

1.18 To review Significant Adverse Event Review findings and ensure completion of resulting action plans Overseeing the development, agreement and review of clinical and care procedures, guidelines and protocols for delegated functions of the HSCP.

1.19 The NHSH Board governance structures should be utilised to ratify clinical policies, guidelines and protocols (e.g. the Area Drugs and Therapeutics Committee for policies relating to medicines, similarly the Council structures should be utilised for care procedures, guidelines and protocols where necessary to meet legal requirements).

1.20 To oversee the Clinical and Care Governance Risk Register and to ensure that risk management procedures are followed across Argyll and Bute to oversee the development of local risk registers and action plans.

1.21 To identify risks requiring attention and report to the IJB as required to ensure that professional standards are adhered to and that systems for governing regulatory requirements for professionals are in place as laid out in the professional Assurance Framework.

1.22 To oversee implementation of framework for professional supervision of clinical and care professionals working in Argyll and Bute to oversee the Clinical and Care Governance Risk Register and to ensure that risk management procedures are followed across Argyll and Bute

1.23 To oversee the development of local risk registers and action plans.

1.24 To identify risks requiring attention and report to the IJB as required to ensure that professional standards are adhered to and that systems for governing regulatory requirements for professionals are in place as laid out in the professional Assurance Framework.

1.25 To oversee implementation of framework for professional supervision of clinical and care professionals working in Argyll and But

AUDIT AND RISK COMMITTEE TERMS OF REFERENCE

REMIT

1.1. To agree the internal audit strategic plan, oversee and review action taken on internal audit recommendations.
1.2. To consider the External Auditor's Annual Audit Plan, Annual Letter, relevant reports, and the report to those charged with governance and other specific External Audit reports.
1.3. To comment on the scope and depth of External Audit work and to ensure it gives value for money.
1.4. To commission work from Internal, External Audit and third parties where appropriate.
1.5. To consider the performance of Internal and External Audit.
1.6. To facilitate training to support the role of Audit and Risk Committee Members.
1.7. To promote a culture of compliance within the IJB to ensure the highest standards of probity and public accountability.
1.8. To support best practice in the financial administration of the IJB.
1.9. To review the IJB's financial performance as contained in the Annual Performance Report, and to report annually to the IJB on the internal control environment.
1.10. There should be a least one meeting a year, or part thereof, where the Audit Committee meets the Internal and External Auditors separately from management.
1.11. The Committee will prepare an annual work plan setting out meeting dates for the financial year and anticipated internal audit, external audit, management reports and scrutiny topics expected to be covered at each meeting.
1.12. The Committee shall prepare an annual report to the IJB covering its activities and key findings each year. This report will be considered at the IJB meeting that agrees the External Auditor's annual audit letter.
1.13. To consider performance and inspection reports from internal audit, external audit and other relevant scrutiny bodies.

2 Regulatory Framework and Risk Management

2.1 To monitor and seek assurance with regard to risk management systems through the review of the effectiveness of risk control measures and corporate governance in the IJB.
2.2. To consider the IJB's compliance with its own and other published standards and controls.
2.3. To monitor the IJB's compliance with the Public Interest Disclosure Act and the Bribery Act in the discharge of its functions.

3 Financial Accounts and Governance

3.1 To examine the activities and accounts of the IJB and exercise a governance role over management efforts to ensure that:

(a) The expenditure approved by the IJB has been incurred for the purposes intended;
(b) Services are being provided efficiently and effectively;

(c) Value for money is being obtained, all in accordance with Best Value requirements; and
(d) The IJB has appropriate information and advice available to them to make decisions.

3.2. To review the annual statement of accounts. Specifically to consider whether appropriate accounting policies have been followed and whether there are concerns arising from the financial statements or from the audit that need to be brought to the attention of the IJB;

3.3. To oversee the production of the IJB's Governance and Internal Control Statement; and support the approach to Best Value.

3.4 To consider the External Auditor's report to those charged with governance on issues arising from the audit of the accounts.

4 Performance Monitoring

4.1 To assess the effectiveness of the IJB's Performance Management Regime;

4.2 To commission specific reviews to be carried out where necessary;

4.3 To review Best Value arrangements and outcomes, with consideration of both external and internal Best Value reports, strategy/plans and outcomes from Best Value reviews; and

4.4 To review the impact of national performance reports from external bodies and consider their impact.

5 Scrutiny

In respect of its scrutiny function:

5.1 The committee defines scrutiny as the process of 'close and critical inquiry' and 'methodical examination' holding others to account through monitoring examination and questioning of decisions actions and performance for the purposes of improvement.

5.2 The committee shall undertake scrutiny reviews at the request of IJB;

5.3 The committee shall receive and undertake requests for scrutiny reviews submitted by any member of the IJB;

5.4 The committee shall itself determine how and when to exercise this function;

5.5 In exercising this function, the committee may call for any inquiry that it considers necessary and may call any individual or for any document or documents it considers relevant to any such investigation;

FINANCE AND POLICY COMMITTEE TERMS OF REFERENCE

REMIT

1. Financial Resources
   1.1. To develop policy strategic objectives and priorities for recommendation to the IJB unless such matters are otherwise delegated.
   1.2. To oversee the management of financial resources on a bi-monthly or as otherwise arranged by the IJB within general provisions before reporting to the Integration Joint Board.
   1.3. To advise the Integration Joint Board on the Revenue Budget and requirements in Capital Planning from the partner bodies.
   1.4. To review adjustments to Management budgets in so far as not delegated to officers within the terms of the financial regulations of the partner bodies and make recommendation to the Integration Joint Board for approval.
   1.5. To consider and advise the Integration Joint Board on the monthly financial monitoring reports
   1.6. To consider and advise the IJB on the medium term financial strategy
   1.7. To advise the IJB on any financial recovery plan required as a result of an overspend.

2. Corporate Asset Management

To liaise with the Council and NHS Highland to ensure that the IJB's future corporate asset management requirements as determined by the Strategic Plan form part of the asset management plans for those parties.

3. Continuous Improvement

   a) To determine and implement the IJB's policies in relation to the achievement of Best Value.

   b) To consider Best Value Reviews from Services as appropriate.

Without prejudice to the duties and responsibilities and delegated authority of other Committees, to review the performance and effectiveness of all the Integration Joint Board's work and the standards and level of service provided, to review the need to retain existing services, and to co-ordinate where necessary all the matters referred to in this sub-paragraph in respect of the Committees and Services of the Integration Joint Board.

4. Transformation
   a) To review financial and policy impacts of Transformational proposals
   b) Oversight of the Service Transformation Board and formal reporting from workstreams

Strategic Planning Group Terms of Reference

1 STATUTORY REQUIREMENT

Section 32 of The Public Bodies (Joint Working) (Scotland) Act 2014 make provision for Integration Authorities to establish a Strategic Planning Group (SPG) for the development and delivery of the Strategic Plan.

The Strategic Planning Group also acts as the point of contact with Locality Planning Groups(LPG's) and subsequently reports LPG activity to the Integration Joint Board(IJB).

2 ROLE

2.1 The role of the Strategic Planning Group is to:

- Receive direction and feedback from the IJB in respect of development of the strategic plan and delivery of the objectives therein over the period of the plan.
- Prepare proposals for the Strategic Plan in regard to the integration delivery principles as described in section 31of the Act:

  The integration delivery principles are:

  (a) that the main purpose of services which are provided in pursuance of integration functions is to improve the wellbeing of service-users;

  (b) that, in so far as consistent with the main purpose, those services should be provided in a way which, so far as possible

  (i) is integrated from the point of view of service-users;

  (ii) takes account of the particular needs of different service-users;

  (iii) takes account of the particular needs of service-users in different parts of the area in which the service is being provided:

  (iv) takes account of the particular characteristics and circumstances of different service-users:

  (v) respects the rights of service-users:

  (vi) takes account of the dignity of service-users:

  (vii) takes account of the participation by service-users in the community in which service-users live:

  (viii) protects and improves the safety of service-users:

  (ix) improves the quality of the service:

  (x)is planned and led locally in a way which is engaged with the community (including in particular service-users, those who look

after service-users and those who are involved in the provision of health or social care):

(xi) best anticipates needs and prevents them arising, and

(xii) makes the best use of the available facilities, people and other resources.

- set out the arrangements for the carrying out of the integration functions for the area of the IJB over the period of the plan;
- setting out how those arrangements are intended to achieve, or contribute to achieving, the national health and wellbeing outcomes, and including such other material as the integration authority thinks fit.

3. REMIT

3.1 The remit of the Strategic Planning Group is directed by the Integrated Joint Board to development and review of the Health & Social Care Partnership Strategic Plan ensuring the alignment of service strategies. The SPG requires to:

- review detailed business cases and change plans on behalf of the IJB
- communicate to the IJB that there's been appropriate discussion and engagement (in line with statutory responsibilities)
- provide a forum for discussion of emerging themes and initiatives that arise following the completion of your strategic plan
- collaborate on the production of future strategic plans
- oversee the delivery of the strategic plan on behalf of the IJB
- Seek the views of the Strategic Planning Group on the proposals;
- Provide the draft plans for consultation;
- Take note of and act upon national policy, guidance, objectives and feedback from the Scottish Government;
- Be responsible for monitoring progress against the strategic priorities and National Health and Wellbeing Outcomes (NHWBO);
- Review the strategic plan annually and monitor progress via production of the Annual Performance Report;
- Ensure there is a process in place to produce a new strategic plan on a 3 yearly cycle, taking cognisance of any updated Scottish Government guidance;
- Provide a view on significant service developments which could impact on the delivery of the strategic plan;
- Is responsible for ensuring Locality Planning Groups produce locality plans which meet local needs and align to the Strategic Plan.

3.2 Strategic Commissioning Planning Role

- A strategic commissioning plan must set out the arrangements for carrying out the integration functions in the Local Authority area over the

period of the Strategic Plan. The area must be divided into a minimum of two localities for this purpose, and the arrangements for each locality must be set out separately.

- A strategic commissioning plan must also set out the way in which the arrangements for carrying out the functions are intended to achieve or contribute towards achieving the national health and wellbeing outcomes.

- The strategic commissioning plan should ensure correlation with other local policy directions as outlines in, for instance, Single Outcome Agreements, NHS Local Delivery Plans, Housing Strategies, NHS Clinical Strategies, community plans and other local corporate plans.

3.3 Locality Planning Groups

- The Strategic Planning Group has a governance role with respect to the Locality Planning Groups and their alignment with the Strategic Plan objectives and the planning "architecture".
- The Strategic Planning Group will assess Locality Action Plans against the progress of the Strategic Plan.

4 Accountability

- Act as a Reference Group to the Integration Joint Board (IJB) and is accountable to the IJB.

5 Membership

The Act further stipulates the membership of the SPG as extracted below, the role and current membership of the Strategic Planning Group is contained in appendix 1.

- Users of health care
- Carers of users of health care
- Commercial providers of health care
- Non-commercial providers of health care
- Health Professionals
- Social Care Professionals
- Users of social care
- Carers of users of social care
- Commercial providers of social care
- Non-commercial providers of social care
- Non-commercial providers of social housing
- Third sector bodies carrying out activities related to health or social care

Appendix 1 FOR INFORMATION

Locality Planning Group Terms of Reference

ROLE OF MEMBERS

- Contribute to relevant local, regional and national consultation responses or events, sharing local experience

- Link local engagement mechanisms with wider stakeholders within their locality to be assured that the community voice can influence locality and strategic planning,

- Share experiences and learning with other locality planning groups in order to shape locality plans and improve joined up working across the wider HSCP.

- Participate in required learning opportunities to maximise individual member contributions

- Develop mechanisms to better understand local need including inequalities, making use of all relevant and available quantitative and qualitative data in relation to their local priorities.

Each member will preside for a 2 year period. If neither chair or vice chair are present the full group will appoint a temporary replacement

FREQUENCY

A minimum of 4 times per year.

QUORUM

Fifty percent of all members should be in attendance.

AGENDA & PAPERS

The agenda and papers for meetings will be issued one week prior to each meeting.

ADMINISTRATION

Recording of meeting activity will be in action note format, disseminated to attendees for agreement and ratification within 2 weeks following the meeting date.

LOCATION

Whenever possible meetings will be held in venues which support video or telephone conferencing.

TRANSPORT COSTS

Volunteer members will have transport costs reimbursed. Please see the NHS Highland volunteer policy for more information.

This page is intentionally left blank

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Integration Joint Board **Agenda item: 7**

Date of Meeting: 25 May 2022

Title of Report: Staff Governance Report for Financial Quarter 4 (2021/22)

Presented by: Jane Fowler, Head of Customer Support Services (ABC)

The Integrated Joint Board is asked to:

- Note the content of this quarterly report on the staff governance performance in the HSCP
- Take the opportunity to ask any questions on people issues that may be of interest or concern;
- Endorse the overall direction of travel, including future topics that they would like further information on.

1. EXECUTIVE SUMMARY

1.1 This report on staff governance performance covers financial quarter 4 (January – March 2022) and the activities of the Human Resources and Organisational Development (HROD) teams. The continued presence of the Omicron variant, has impacted on the delivery of learning and development courses. Generally during this time, there has been an ongoing focus on supporting employee health and wellbeing, recruitment processes and supporting employee relations.

2. INTRODUCTION

2.1 This report focuses on how staff governance supports the HSCP priorities and meets the staff governance standard. Staff Governance is defined as "A system of corporate accountability for the fair and effective management of all staff." The Standard requires all NHS Boards to demonstrate that staff are:

- Well informed
- Appropriately trained and developed
- Involved in decisions
- Treated fairly and consistently, with dignity and respect, in an environment where diversity is valued; and
- Provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff patients and the wider community.

2.2 In the context of health and social care integration, we also consider the following:

- Adopting best practice from both employers
- Development of joint initiatives that support integration
- Compliance with terms and conditions and employing policies

3. PROGRESS AND CHALLENGES

3.1 Culture

3.1.1 The Argyll and Bute HSCP Culture Group was renamed as the Culture and Wellbeing Group to reflect the impact and priority of workforce wellbeing. In the last quarter, actions taken to improve culture include:

- Staff communication updates continue weekly with information on key issues of interest to staff via NHSH Staff Communications.
- The Chief Officer issues regular all staff email updates and blogs.
- A SLWG was convened to restart the Connections programme with an emphasis of hearing from all staff areas. Spaces for listening was also offered. These have been well received by colleagues
- Continued to promote the Guardian Service to staff and there are now regular engagement sessions with the HR teams to identify areas for particular attention.
- We continue to agree and share 3 key messages via the Staff Communications after each meeting so that staff can see what is being discussed and are encouraged to participate in the group.

3.1.2 The Culture and Wellbeing group members are participating in 6 priority workstreams as part of the overall Culture programme with colleagues in north Highland to drive forward culture change across Highland and Argyll and Bute. The priority workstreams have made the following progress:

- Values and Behaviours – embedding these by incorporating in a Team Conversations session. Due to continued System pressures this has been further delayed and it is anticipated arrangements for a soft launch will be introduced by the beginning of June 2022.
- Civility Saves Lives workshops will start in Q1
- Leadership and Management Development Programme – . Due to continued System pressures the programme has been further delayed until April 2022 for levels 1, 2 and 3; and until May for Level 4.
- People Process Review – providing clarity of roles and responsibilities, improving overall performance and reporting and improving incidence of early resolution; recommendations are being implemented
- Root Cause Diagnostic – identifying system failures and their impact, taking forward lessons learned. This work has been completed.

- Culture Metrics and Tools – develop, implement and review a suite of metrics; a culture dashboard is being developed for managers to assess where support is needed. A Listening and Learning staff survey was undertaken in 2021 with 41% engagement. Teams received results that will help to inform their action plans. The survey results have been reported separately.
- A Culture Roadmap is expected to raise awareness of initiatives and progress for teams across Highland. Key milestones will feature on the roadmap, and this is expected to be introduced as part of the overall communications campaign.

3.1.3 Future plans include:

- The Culture and Wellbeing group will continue the Culture Work and be more inclusive, with the aim to explore all issues that staff experience in the workplace
- It will review the true impact of Integration on all staff in their roles across the HSCP
- Exploration of how to increase engagement from Council colleagues as the group is predominately populated by NHSH staff at present
- Exploring and facilitating members being informed in areas of Culture and Wellbeing, and Decision-Making Models through support from library services in terms of ebooks and information sharing
- Seeking further diversity of group membership
- The Terms of Reference and Plan to be revised and amended to reflect current situation with priorities being identified for the coming year

3.1.4 **Courageous Conversations** sessions continue to be delivered via MS Teams and can be booked by teams as well as individuals, from both Council and NHS. Progress on design of eLearning continues to be made however there is a delay with the module expected to be ready for testing in the next quarter. Participate was low this quarter due to resource challenges associated with Omicron. Only 2 employees attended this course. However, we anticipate that participation rates will increase once the e-learning module is available and the impact of Omicron has passed, freeing up employees up to attend training and participate in learning.

There are a number of changes being made in the Talent Service and a new OD Team being formed. The focus of the Education, Learning and Development Team will be on Lifelong Learning, Leadership and Management Development and Promoting Careers. It is anticipated these structural changes will enable more capacity to promote learning.

3.2 **Wellbeing**

3.2.1 **HSCP Guardian Service**

The Guardian Service was extended from 1 January 2021 to cover Argyll and Bute Council employees working for Argyll and Bute Health and Social Care Partnership.

The year end data confirms that across NHS and Council there have been 65 cases supported by through the Guardian Service centring round the same themes that have already reported to committee; Management Issues, , Behaviour Relationship, perceptions of Bullying and Harassment and System and Process issues, and the guardian service are supporting and guiding employees with these concerns.

In quarter 4 there was an increase in contact with 24 new cases with management issues being the most prevalent reason for contact. Site visits reconvened in March which may account for the increase in contact but it is also important to note that March and April were the busiest months last year too. Conversations are taking place with the Guardian service to understand the themes and issues prevalent in Argyll and Bute and link this where appropriate with the work underway across culture, wellbeing and learning and development seeking to improve employee experiences. A more detailed report will be provided by the Guardian service at the end of May which will further inform actions and updates will continue to be reported in future reports.

In June 2022 the Council will launch a new Conflict Resolution Toolkit for line managers to support managers to take action when issues are raised with them. Alongside this there will also be corporate training available from ACAS on Conflict Resolution. This is particularly relevant for issues of behaviour relationship highlighted above.

3.2.2 **Council Wellbeing Team**

The Wellbeing Team continue to actively promote the Employee Assistance Programme, Wellbeing App and structured counselling provision. They provide ongoing support and advice for managers and employees in relation to supporting attendance and will start to implement new wellbeing initiatives in the coming months such as on-line physio, an active care service, Employee Assistance Programme (EAP) and targeted wellbeing improvement plans. Communications to go out to staff in the coming weeks and further details will be provided to the next IJB.

Wellbeing Wednesday features a range of Wellbeing topics and signposting to relevant support agencies, which is available to all staff here: My Wellbeing – My Council Works

3.2.3 The OD team offered Spaces for Listening sessions to all HSCP staff in collaboration with colleagues across other boards and the Scottish Ambulance Service. This is a structured process which creates a space to share thoughts and feelings and experience an equality of listening. Further dates are offered, in partnership with NHS Grampian, on an ongoing basis with additional promotional material being generated.

In collaboration with the Chaplaincy Service , OD have developed ‘Take 5’ sessions, offering a pause in the working day with a guided reflection or mindfulness practice. This offer is due to commence in FQ1.

3.2.4 A Self Care intervention and a Self Care/Wellbeing module have been designed and developed as part of the NHSH Leadership and Management Development programme and in response to requests from colleagues Delivery was paused due to Omicron and the start date for delivery will be from FQ1.

3.2.5 A focus for Quarter 1 is to:

- Continue to promote wellbeing resources
- Continue to offer Spaces for Listening
- Offer self-care intervention
- Offer Take 5 sessions
- Consider staff wellbeing alignment with the culture programme and the priorities for 2022/23

3.3 **Learning and Development**

3.3.1 A & B Council recently revised and updated the approach to performance discussions, now focusing more on measuring and improving outcomes. Improving the conversations managers and employees have about performance, behaviours and career/development aspirations.

The Weekly webinars were set up to answer any questions and provide additional support and were very well attended and have now concluded. Further information and guidance has been made available here: Changes to the annual PRD process – My Council Works

Council Face to Face training is now occurring with more regularity as Covid restrictions have eased. Some statistics for the face to face training courses held during FQ4 are available at Appendix 7.

Appendix 6 shows generally no change to the Appraisals Performance Data levels for completed staff appraisals for NHS staff within Argyll and Bute HSCP.

There is still a need to focus on employee development and provide support and positive reflection on the achievements of the past year. The Council is currently reviewing the PRD process, based on feedback, in order to improve it and progress will be reported.

3.3.2 Improving compliance with Statutory and Mandatory training is essential to the safety and quality of services that the HSCP delivers. This continues to be an area of concern. The compliance levels are shown in Appendix 7a and 7b and indicate that compliance levels have not changed for induction and mandatory training. There is an NHSH wide focus on improving performance on completion of mandatory training and HROD are exploring how best to support completion across the HSCP . Key performance indicators will be reported to SLT from FQ1 2022/23.

3.3.3 The Education, Learning and Development Team continues to explore ways to improve SVQ accessibility for NHSH staff within A&B HSCP and work with the NHSH SVQ centre. The team will have a key theme of work related to promoting careers and part of their focus will be on Growing Our Own, maximising on Apprenticeships and SVQs as well as enabling improved opportunity for pre-employment placements. Talent attraction and engagement will also be a priority working closely with professional leads and service managers. Further information on progress and plans will be brought to a future IJB meeting.

3.4 Leadership and Management Development

3.4.1 Manager Induction Programme

The Induction programme for managers in the new structure started in February 2021 and runs at monthly intervals throughout the year. Each four-hour session is delivered remotely via MS Teams making the programme more accessible for everyone, particularly managers based on islands. The programme focuses on HSCP manager responsibilities and accountabilities and ensuring that managers are supported.

The themes covered include:

- Values, behaviours, roles and responsibilities; partnership working
- Managing your team
- Spotlight on Services
- Clinical Care and Governance
- Your development – further leadership and management development programmes

The managers induction programme was paused during the last quarter due to System pressures and attendance stats remain as reported last quarter.

3.4.2 Leadership and Management Development Programme was also paused due to system pressures. Timescales for delivery have been reviewed accordingly and as a supportive measure Learning Journals will be optional for delegates with the opportunity to explore any need for Action Learning sets.

A Pilot Mentoring programme for levels 2 and 3 has been introduced and early evaluation indicates this is positively received. Plans are being made to offer mentoring for leaders and managers across the organisation.

Blended learning can have an impact on the strength of relationships between delegates and facilitators. Through consideration of Action Learning Sets and exploring the need for a Leadership Community for all leaders and managers, it is expected that the profile of leadership as a profession can be positively supported and promoted.

3.4.3 Once for Scotland workforce policies courses have been delivered remotely for all managers to ensure up-to-date knowledge of the new NHS Scotland policies. As a result of the pressures created by the pandemic delivery of sessions was paused in Q3 with no sessions delivered during Q4. These will resume to normal service from April 2022 onwards and attendance will be reported accordingly

3.5 Resourcing: Recruitment and Redeployment

3.5.1 Attracting and retaining suitable applicants predominantly within nursing and some AHP roles remains challenging across all areas particularly Oban, Lorn and Isles locality and within Mental Health Inpatient Services, however now that we have the new Generic/Cohort mass recruitment we are hoping to see this improve significantly. A strategic approach is being taken to this, led by the HR Director of NHSH. The Communications Team continues to support the recruitment by sharing posts and information relating jobs throughout the UK to relevant groups and contacts on social media. Recruitment colleagues have also been shown the Hootsuite and are able to share posts to the Highland Recruitments social media platforms. Further work is to be done to highlight health posts via www.abplace2b.scot

The HR and OD team have been working with Social Care colleagues to develop proposals for posts which could better support the care recruitment requirements. Job descriptions have been developed and reviewed by the job evaluation team. These proposals will be reviewed at a resources managers meeting in March 2022.

Further details are shown in Appendix 3.

3.6 My HR – My Council Works

We are continuing to transfer staff information onto My Council Works which is externally facing and therefore accessible to all staff; not just those who use the internal network. This is not only a useful tool for all council staff, but also very useful for the NHS managers who manage council employees, for ease of accessing Council policies. The majority of policies have now been uploaded and we will ensure future policies are included on this external hub.

4. RELEVANT DATA AND INDICATORS

4.1 Attendance

4.1.1 HSCP NHS absence levels have been on a downward trend from last quarter, just above the national target of 4%. After peaking at just under 10% for last quarter, Children & Families Service's absence levels have decreased significantly to comparable levels with other services within Q4. The percentage absence for NHS employees for Quarter 4 are:

- January: 5.36%
- February: 5.07%
- March: 4.45%

4.1.2 The Council data at Appendix 1b, is showing a very slight increase in absence levels during FQ4. In December 2021 the average for HSCP was 2.15 days lost per FTE per month, with March showing a slight increase to an average of 2.27. Work continues by both HR and the Wellbeing Teams to support the management of long and short -term sickness absence.

Further details are shown in Appendices 1a and 1b. There is an additional rolling graph at Appendix 1c, showing a comparison of Covid-related and non-Covid related absence within Council employees. The number of non-Covid related absence remains higher than that of Covid-related cases in FQ4, although there was a peak mid February to mid March – but that has gradually subsided towards the end of the Quarter.

4.1.3 **Return to Work Interviews**

Return to Work Interviews are an important aspect of looking after our employees. They are recorded and reported for Council staff, with a target rate of 100% completion within 3 days of returning to work. This is a key component of attendance management. The rates for Q4 have shown an overall increase, from an average of 38% completion rate in January 2022 to an average 61% completion rate at the end of March 2022. This is a positive development which will be built on in Quarter 1 to strive for 100% completion. Ensuring that these interviews are being completed after all absences regardless of length remains a priority. The chart detail is shown in Appendix 2 below.

4.1.4 The Once for Scotland Attendance Management Policy training was halted during Quarter 4 due to the Omicron response activity. This will re-commence in Quarter 1

4.2 **Redeployment**

4.2.1 All NHS vacancies are considered for both Primary and Secondary redeployment lists as they arise. The HR team continue to work in partnership with the Area Manager and Staffside/TU Rep in securing permanent, temporary and shadowing opportunities. As a result, in Quarter 4, the numbers of staff on the redeployment primary list continues on a downward trend as seen in Appendix 4.

4.2.2 Appendix 4a continues to highlight the numbers of temporary and casual workers that we have in the HSCP. Quarter 4 shows there is a slight upward trend of appointing temporary employees and the use of casual workers.

4.3 **Employee Relations (ER)**

4.3.1 In Q4, within the NHS caseload, there were 3 grievances and 1 conduct case closed. There were 1 new grievance and 1 bullying & harassment cases added to the caseload within the quarter. Further details are shown in Appendix 5 where it shows a fairly static trend of a relatively low number of ongoing ER cases in comparison with the beginning of the financial year.

4.3.2 HSCP Council Disciplinary and Grievance cases are continuing to show an overall downward trend during Q4. There has been 1 Grievance lodged in Q4 within HSCP Council area. This is currently ongoing. Within Q4, there have been 3 completed Disciplinary cases which have resulted in formal warnings. There are 2 cases ongoing which are within Appeal timescale. Details are shown on the charts at Appendix 5b.

5. WORK PLANNED FOR THE NEXT 3 MONTHS

5.1 **Update on work for FQ4 and plan priorities for FQ1:**

AB HSCP Culture and Wellbeing Group – refresh plan and group membership, terms of reference	FQ1
Continue delivery of Courageous Conversations, management development; improvement to people processes	Restart after standing down in FQ4
Roll out the iMatter survey in Quarter 1 to allow managers can produce action plans with their teams (Reporting anticipated August Q2	FQ1/2
Continue to support Staff Health and Wellbeing activities to align with Council and support the improvement of HSCP sickness absence	Wellbeing Group established; work ongoing
Continue to support aspects of the Culture programme and workstreams including Team Conversations	Restart after standing down in FQ4
Seek to understand the outputs from the Listening and Learning survey and what is needed as a result; create action plans incorporating results from this survey and iMatter	FQ1/2
Progress to 100% of all vacancies on JobTrain – plan roll out with service managers – roll-out delayed due to staff changes/availability and considerable resourcing workload	Ongoing
Progress workforce planning; eESS training required for HROD and all managers (NHSH to deliver)	Restart after standing down in FQ4
Deliver Once for Scotland to all managers and then staff – delivered remotely via MS Teams	Restart after standing down in FQ4

6. CONTRIBUTION TO STRATEGIC PRIORITIES

6.1 This report has outlined how the staff governance work contributes to strategic priorities.

7. GOVERNANCE IMPLICATIONS

7.1 **Financial Impact**

A reduction in sickness absence will reduce costs.

7.2 **Staff Governance**

This staff governance report provides an overview of work that contributes to this theme.

7.3 **Clinical Governance**

None.

8. EQUALITY & DIVERSITY IMPLICATIONS

Equality and Diversity implications are considered within the NHS People and Change and Council HROD teams as appropriate when policies and strategies are developed.

9. RISK ASSESSMENT

Risks are considered medium. Individual HROD risks identified on the Risk Register. Risk assessments have been completed in relation to remobilisation.

10. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

The Everyone Matters pulse survey was reported in this quarter.

11. CONCLUSIONS

It is recommended that the Integration Joint Board:

- Note this quarterly Staff Governance update;
- Take the opportunity to ask any questions on people issues that may be of interest or concern;
- Endorse the overall direction of travel, including future topics that they would like further information on.

12. DIRECTIONS

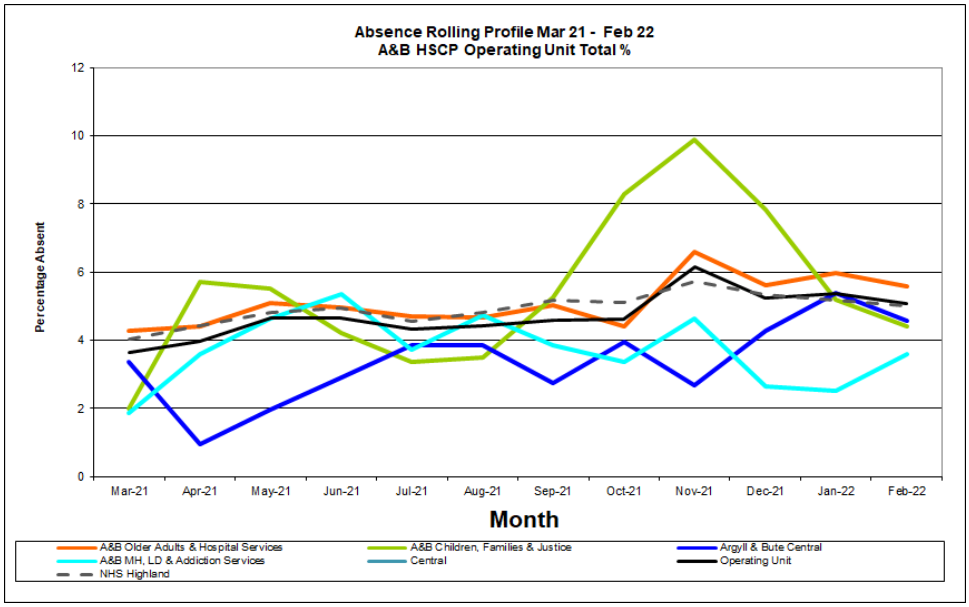
	Directions to:	tick
Directions required to Council, NHS Board or both.	No Directions required	✓
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

REPORT AUTHOR AND CONTACT

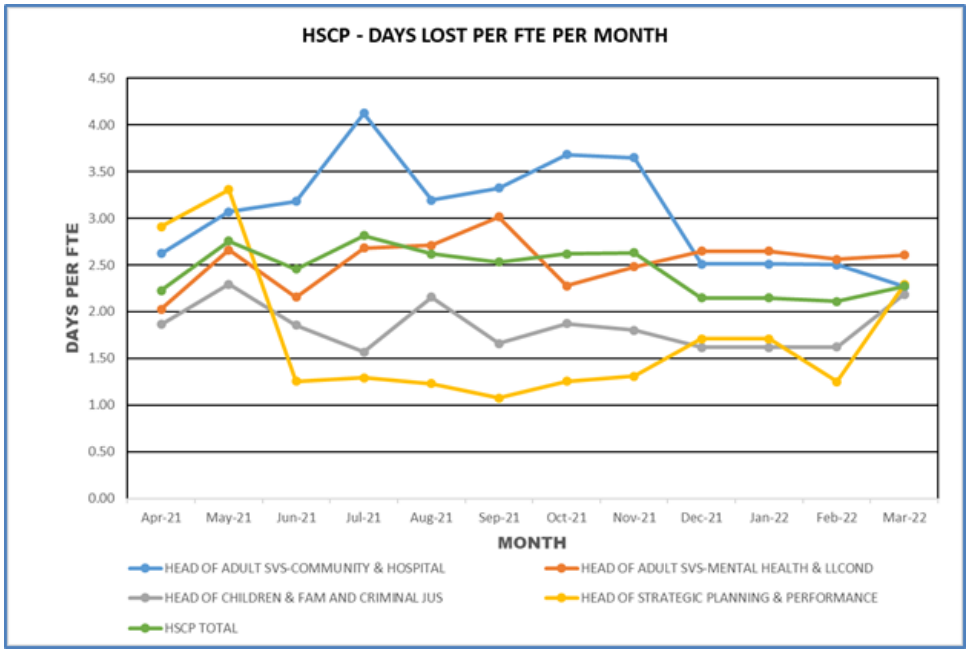
Charlie Gibson, HR Lead, NHS Highland charlie.gibson@nhs.scot
Jo McDill, HR&OD Officer, Argyll and Bute Council hr-hscp@argyll-bute.gov.uk
Dorothy Ralston, HR&OD Officer, Argyll and Bute Council hr-hscp@argyll-bute.gov.uk
Geraldine Collier, People Partner, NHS Highland geraldine.collier@nhs.scot

Appendix 1a – HSCP Absence rates – NHS employees

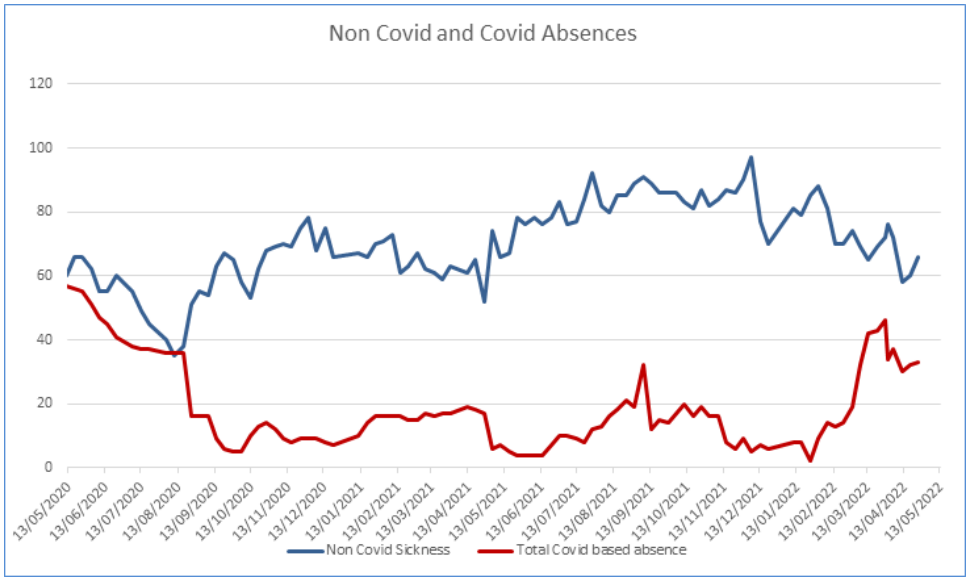
NHS



Appendix 1b – HSCP Absence rates Council Employees

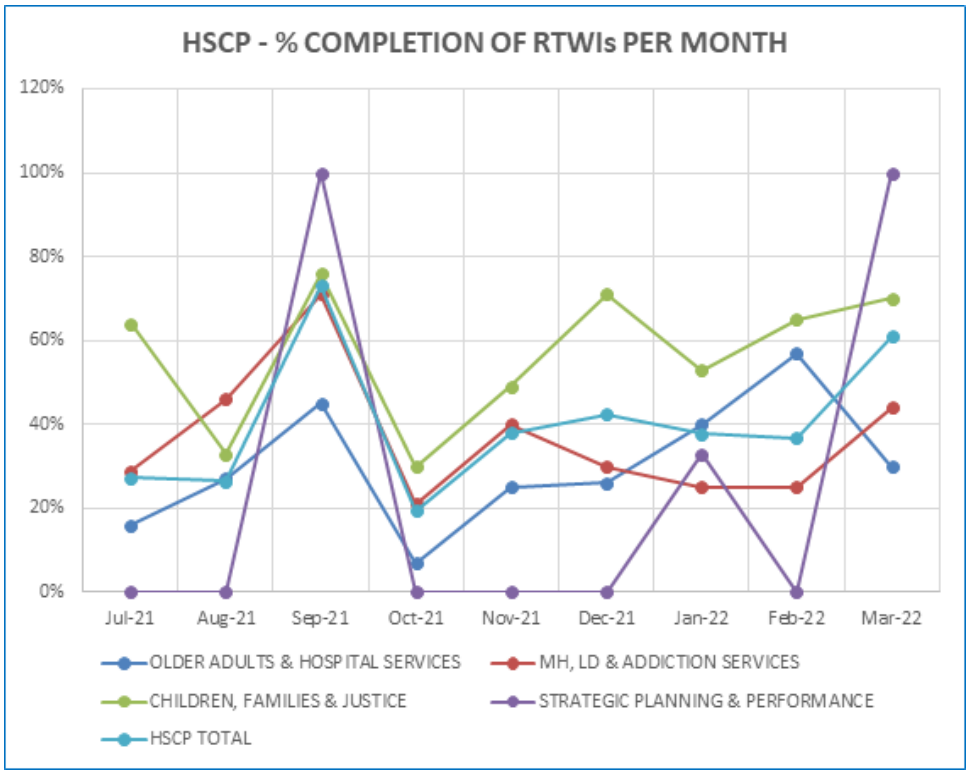


Appendix 1c – HSCP Council Employees – Non Covid vs Covid Absences



Appendix 2 – Return to Work Interview Data (Council Staff) FQ4

The graph below shows the completion rates for Return to Work Interviews (RTWI) across the partnership for Council staff. The target is 100% completion within 3 days of the employee returning to work. The graph depicts the trends in completion rates since July 2021. Whilst there have been a few dips in the % completion rates, it is positive to see an overall improvement in these completion rates towards the end of FQ 4. The Wellbeing Advisors continue to advise and guide managers on the long term absence cases.

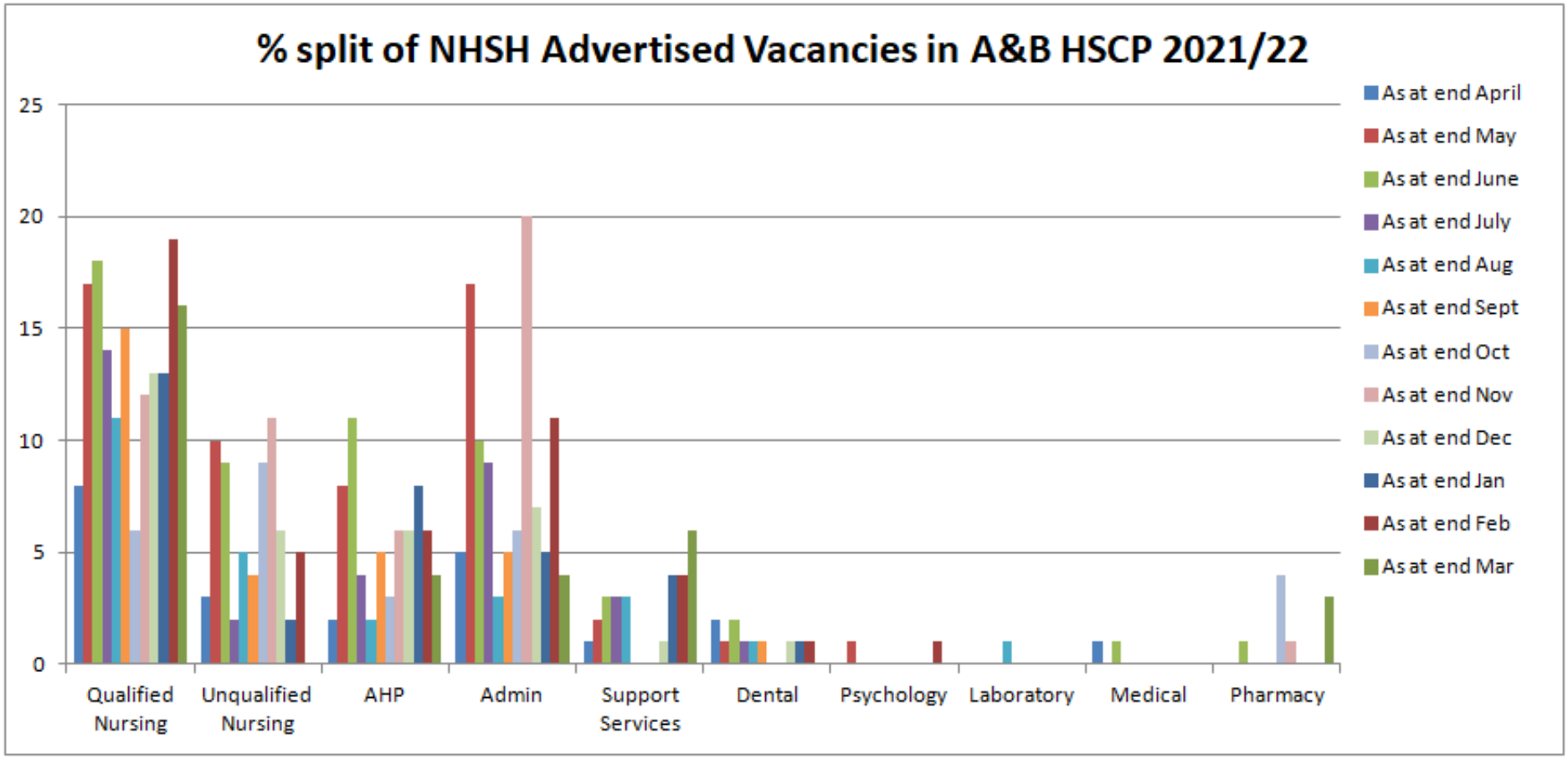


Appendix 3 – Recruitment and Redeployment Activity (Q3)

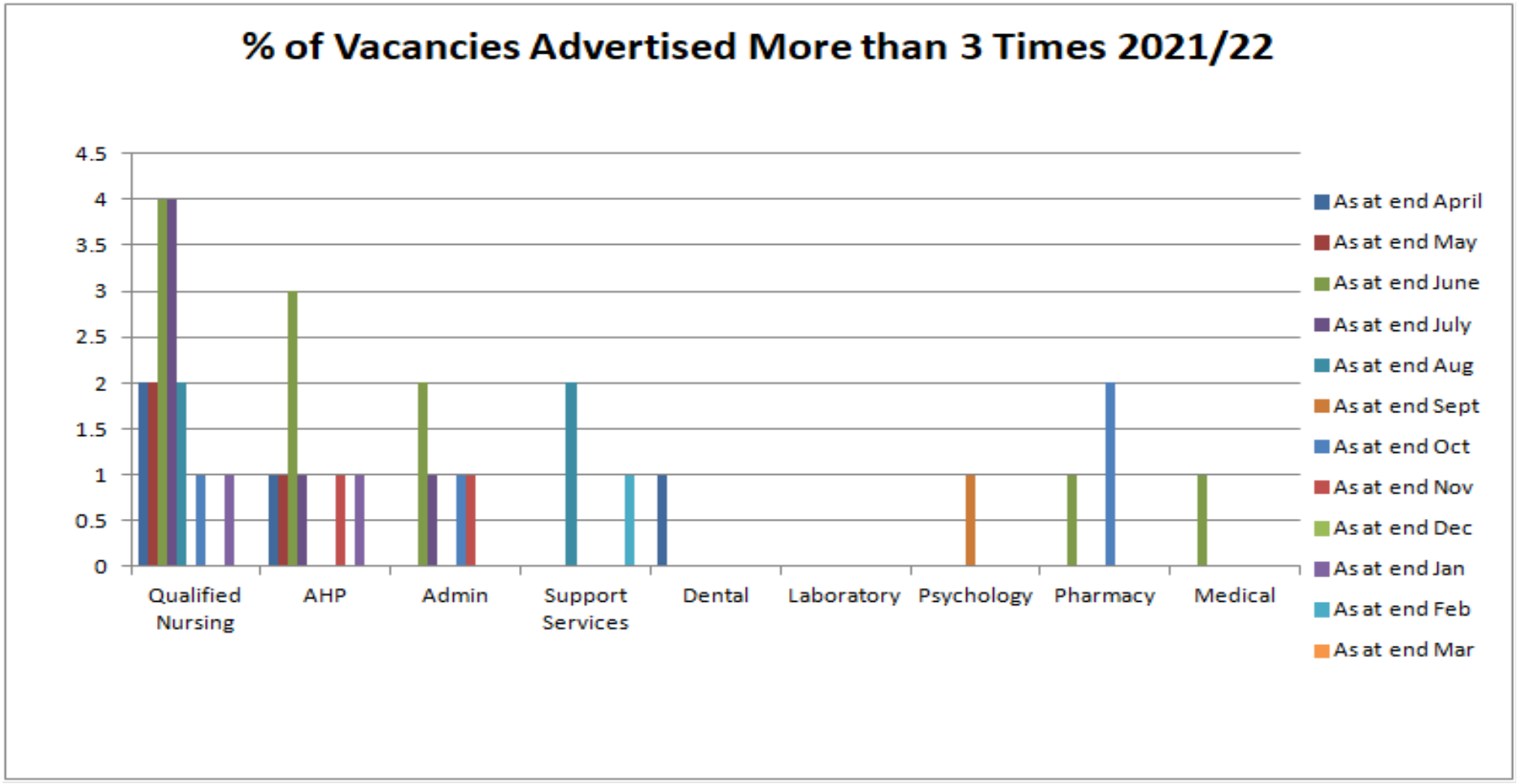
3a NHS Vacancies

	January		February		March	
	New	Re-Ad	New	Re-Ad	New	Re-Ad
Adult Services EAST	6	0	10	0	5	6
Adult Services WEST	20	1	30	3	25	3
Children & Families	3	1	2	1	4	0
Corporate Services	2	0	2	0	6	0
Totals	31	2	44	4	40	9
	33		48		49	

Appendix 3b NHS Advertised Vacancies



Appendix 3c NHS Re-advertised Vacancies

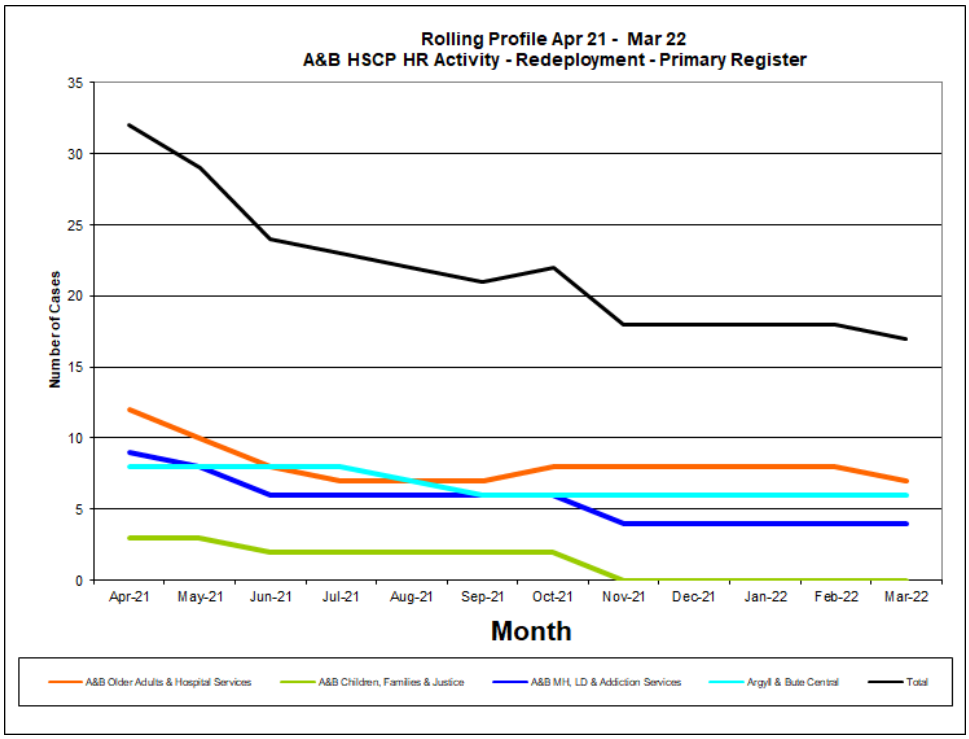


Appendix 3d Council Social Work/Care vacancies

The breakdown of Council vacancies (detailed by Internal/Ring-fenced and External job adverts) for Q4 is detailed in the table below. The Council's Communications Team continues to promote vacancies on social media, as well as the main external adverts via the My Job Scotland website.

	Jan 22		Feb 22		Mar 22	
	Internal/RF	External	Internal/RF	External	Internal/RF	External
Older Adults & Hospital Services	1	10	2	6	5	30
MH, LD & Addiction Services	1	2	0	1	2	2
Children, Families and Justice	4	4	5	8	4	12
Strategy P&P	0	0	0	0	0	0
(HSCP PL3 DIRECTORATE)						
	6	**16**	**7**	**15**	**11**	**44**
Totals	**22 (Temp 4) (Perm 18)**		**22 (Temp 10) (Perm 12)**		**55 (Temp 18) (Perm 37)**	

Appendix 4: NHS Redeployment



Appendix 4: Permament, Fixed Term and Casual Contracts (Q4)

4a NHS and Council Social Work/Care Temporary (including Secondments) /Fixed Term Contracts

Employees on T/FT contracts	Jan 22	Feb 22	Mar 22
Older Adults & Hospital Services (ABC)	32	34	33
Older Adults & Hospital Services (NHS)	2	2	2
MH, LD & Addiction Services (ABC)	10	10	10
MH, LD & Addiction Services (NHS)	2	2	2
Children, Families and Justice (ABC)	18	19	20
Children, Families and Justice (NHS)	12	12	12
Strategic Planning and Performance (ABC)	0	0	1
Corporate Services (NHS)	3	3	2
(HSCP PL3 DIRECTORATE ABC)	3	3	3
OVERALL TOTAL	**82**	**85**	**85**

4b Council Social Work/Care Casual Workers

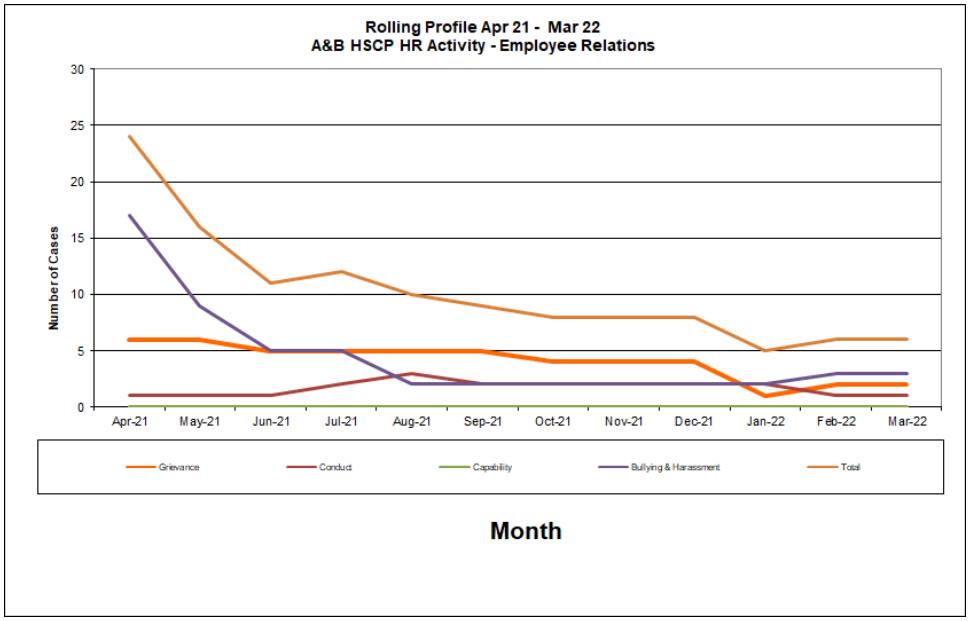
Total Number of Casual Workers (some also on Perm/Temp contracts)	Jan 22	Feb 22	Mar 22
Older Adults & Hospital Services	558	562	550
MH, LD & Addiction Services	152	155	158
Children, Families and Justice	194	196	197
OVERALL TOTAL	**904**	**913**	**905**

Appendix 5 – Employee Relations Cases

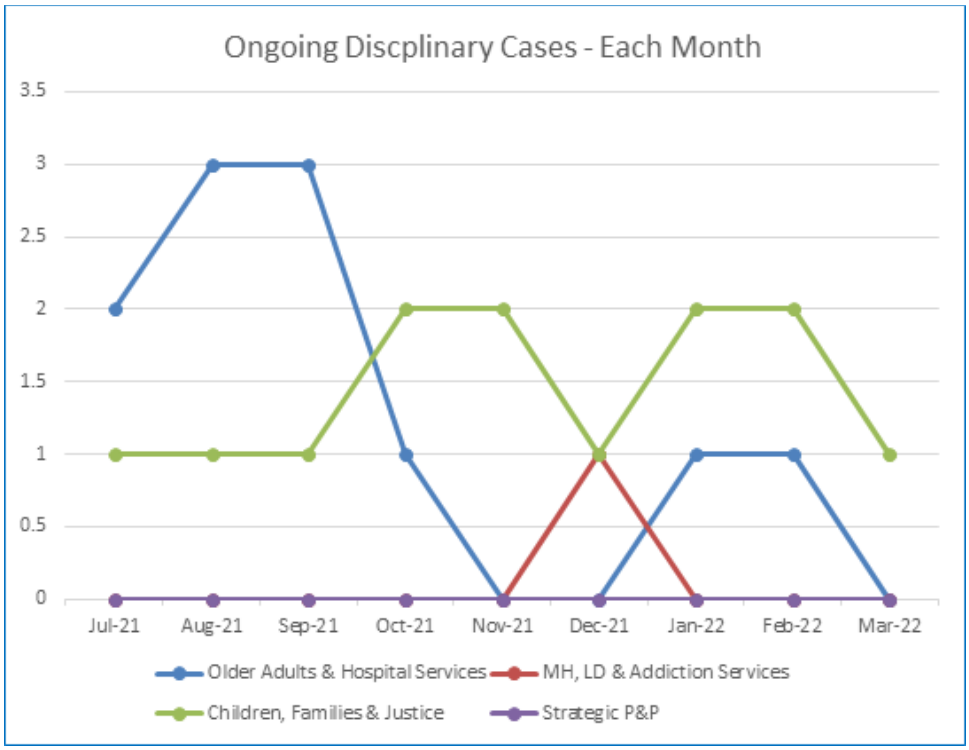
5a NHS ER cases

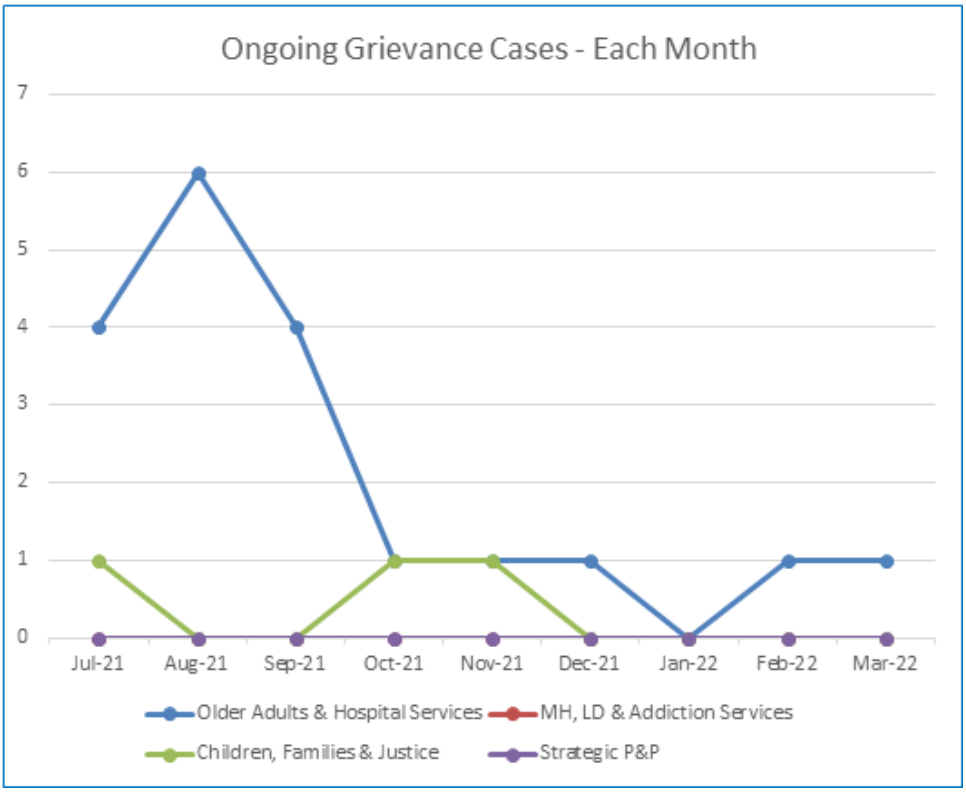
NHS	Jan 22	Feb 22	Mar 22	Q4 New	Q4 Completed/ Closed
ER ALL					
Grievance	1	2	2	1	3
Conduct	2	1	1	0	1
Capability	0	0	0	0	0
Bullying & Harassment	2	3	3	1	0
Totals	5	6	6	2	4

NHS



Appendix 5 b - Council Social Work/Care ER cases

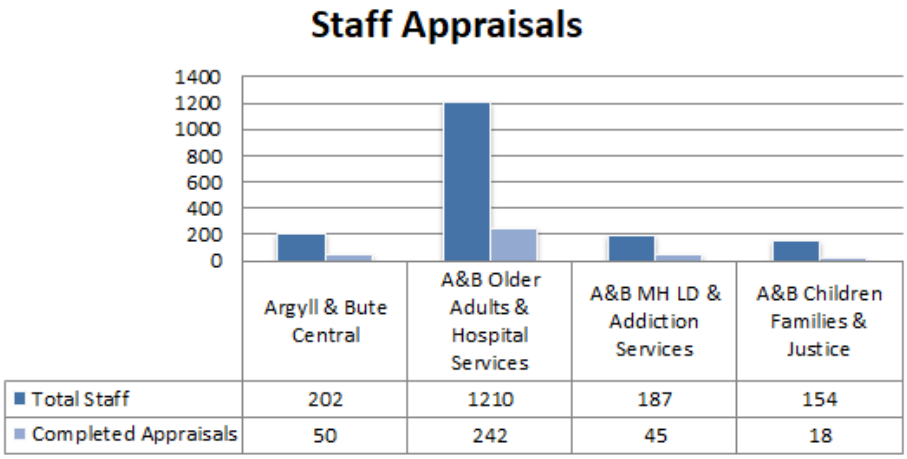




Appendix 6 – Argyll & Bute HSCP Staff Appraisal Data

Monthly appraisal performance data for each area can be access via sway presentation (click here) and monthly reports published on intranet (click here).

The chart below shows the completed appraisal within last 12 months at the end of March 2022.

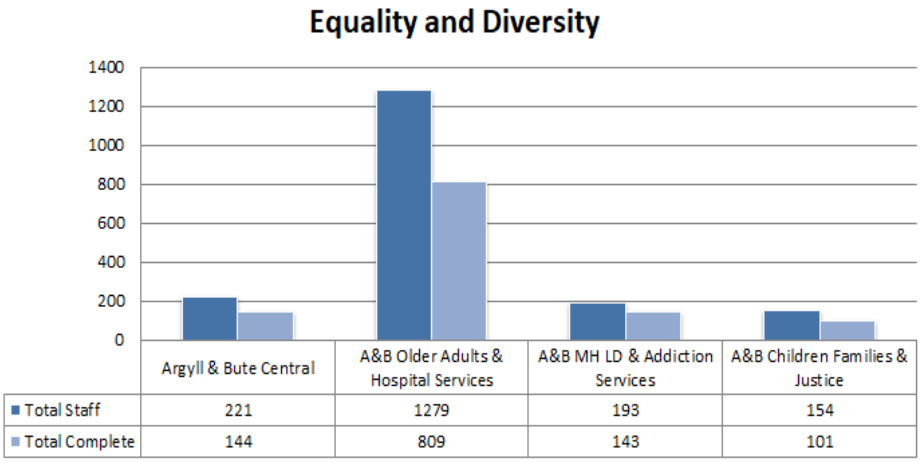


	Argyll & Bute Central	A&B Older Adults & Hospital Services	A&B MH LD & Addiction Services	A&B Children Families & Justice
Total Staff	202	1210	187	154
Completed Appraisals	50	242	45	18

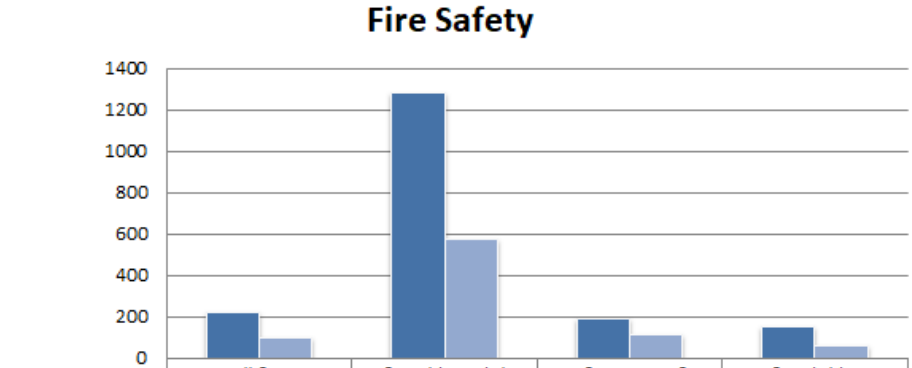
Appendix 7 a – Argyll & Bute HSCP Performance Compliance Data – Ongoing

Monthly compliance data for each area can be access via sway presentation (click here) and monthly reports published on intranet (click here).

The charts below show the A&B HSCP compliance percentage at the end of March 2022.

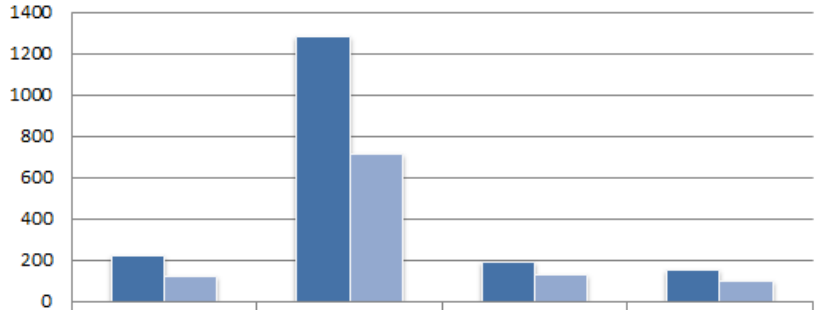


	Argyll & Bute Central	A&B Older Adults & Hospital Services	A&B MH LD & Addiction Services	A&B Children Families & Justice
Total Staff	221	1279	193	154
Total Complete	144	809	143	101



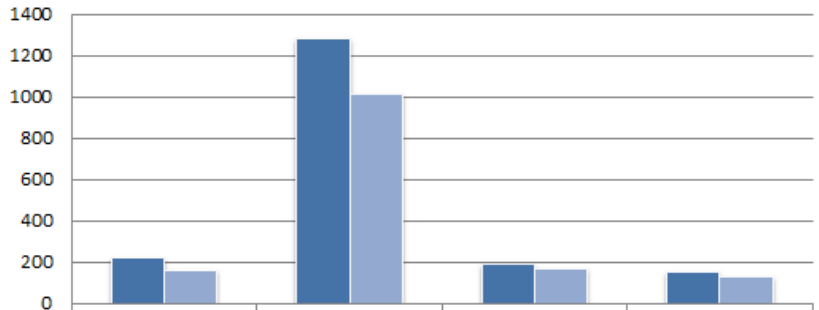
	Argyll & Bute Central	A&B Older Adults & Hospital Services	A&B MH LD & Addiction Services	A&B Children Families & Justice
Total staff	221	1279	193	154
Total Complete	96	572	116	60

Safe Information Handling - Foundation



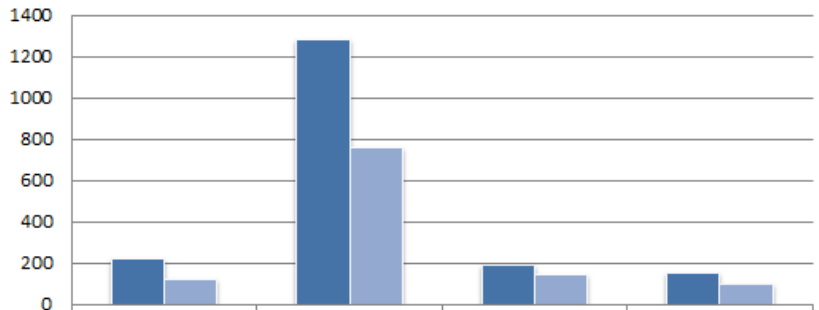
	Argyll & Bute Central	A&B Older Adults & Hospital Services	A&B MH LD & Addiction Services	A&B Children Families & Justice
Total Staff	221	1279	193	154
Total Complete	118	713	131	98

Hand Hygiene



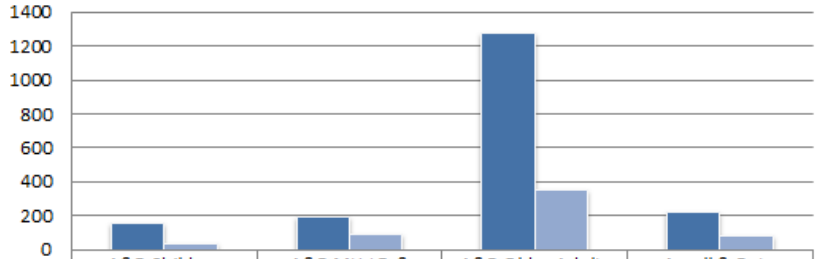
	Argyll & Bute Central	A&B Older Adults & Hospital Services	A&B MH LD & Addiction Services	A&B Children Families & Justice
Total Staff	221	1279	193	154
Total Complete	160	1009	166	127

Moving and Handling - Module (A)



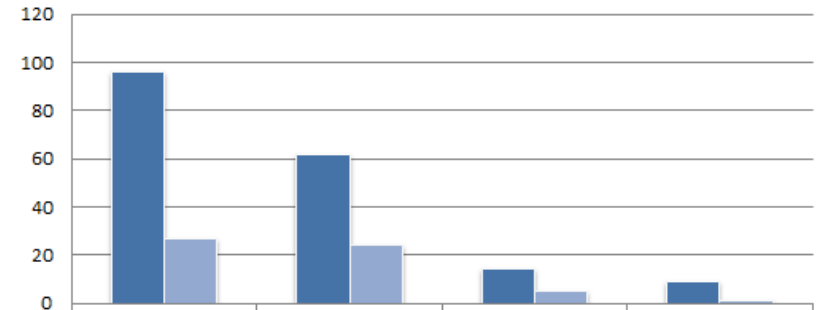
	Argyll & Bute Central	A&B Older Adults & Hospital Services	A&B MH LD & Addiction Services	A&B Children Families & Justice
Total Staff	221	1279	193	154
Total Complete	122	755	144	98

Public Protection: Everyone's Responsibility



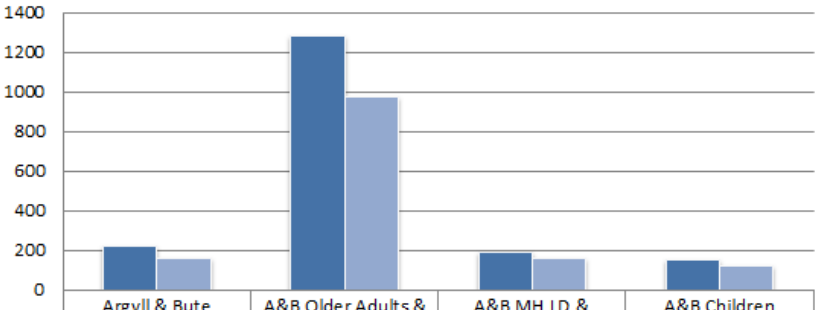
	A&B Children Families & Justice	A&B MH LD & Addiction Services	A&B Older Adults & Hospital Services	Argyll & Bute Central
Total Staff	154	193	1279	221
Total Complete	34	92	353	77

Violence and Aggression (Non-Clinical)



	Argyll & Bute Central	A&B Older Adults & Hospital Services	A&B MH LD & Addiction Services	A&B Children Families & Justice
Total Staff	96	62	14	9
Total Complete	27	24	5	1

Why Infection Prevention and Control Matters



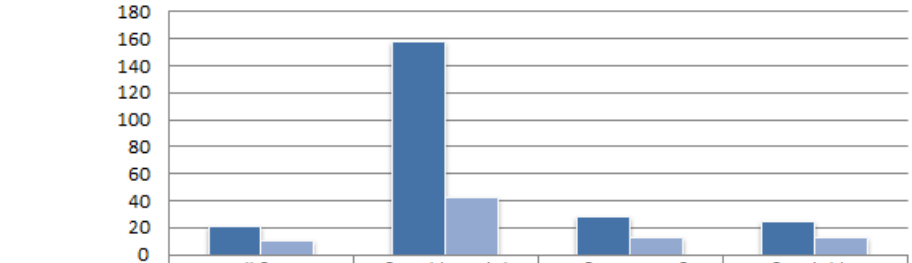
	Argyll & Bute Central	A&B Older Adults & Hospital Services	A&B MH LD & Addiction Services	A&B Children Families & Justice
Total Staff	221	1279	193	154
Total Complete	158	971	162	124

Appendix 7 b – Argyll & Bute HSCP Performance Compliance Data – Induction

Monthly compliance data for new starts in each area can be access via sway presentation (click here) and monthly reports published on intranet (click here).

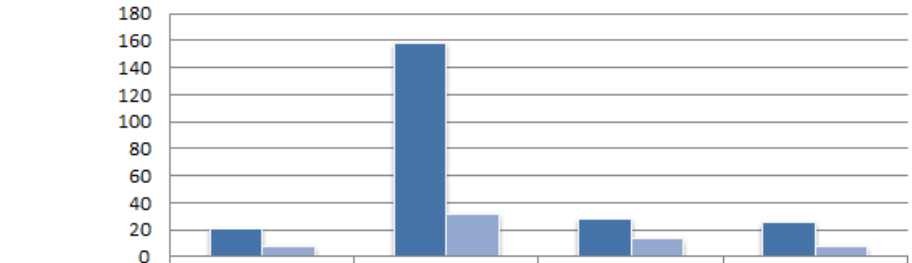
The charts below display compliance with core mandatory elearning requirements at the end of March 2022.

Corporate Induction



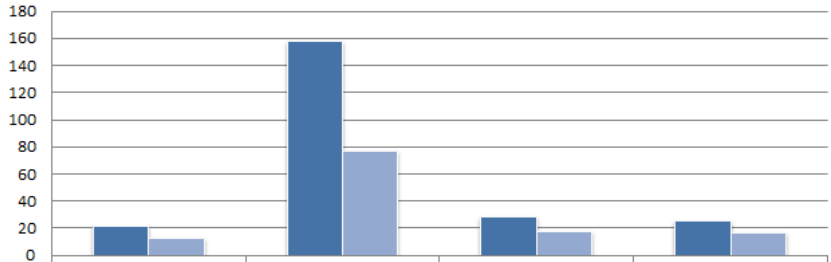
	Argyll & Bute Central	A&B Older Adults & Hospital Services	A&B MH LD & Addiction Services	A&B Children Families & Justice
Total Staff	21	158	28	25
Total Complete	10	42	13	12

Local Induction



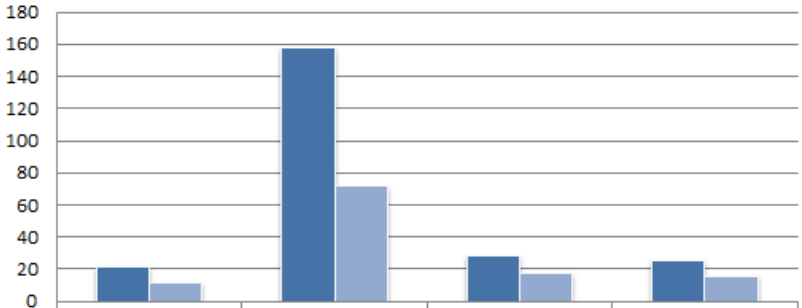
	Argyll & Bute Central	A&B Older Adults & Hospital Services	A&B MH LD & Addiction Services	A&B Children Families & Justice
Total Staff	21	158	28	25
Total Complete	7	32	13	7

Equality and Diversity



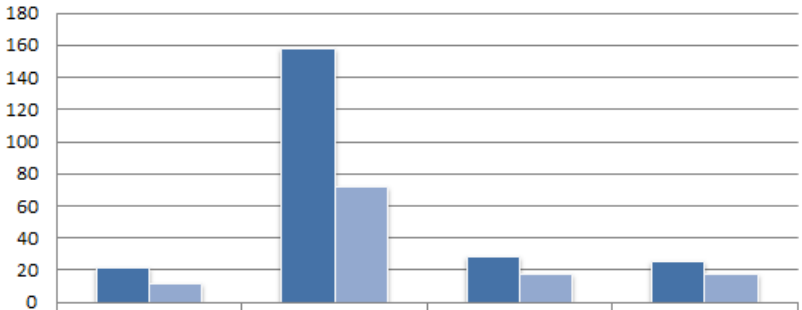
	Argyll & Bute Central	A&B Older Adults & Hospital Services	A&B MH LD & Addiction Services	A&B Children Families & Justice
Total Staff	21	158	28	25
Total Complete	13	77	17	16

Fire Safety



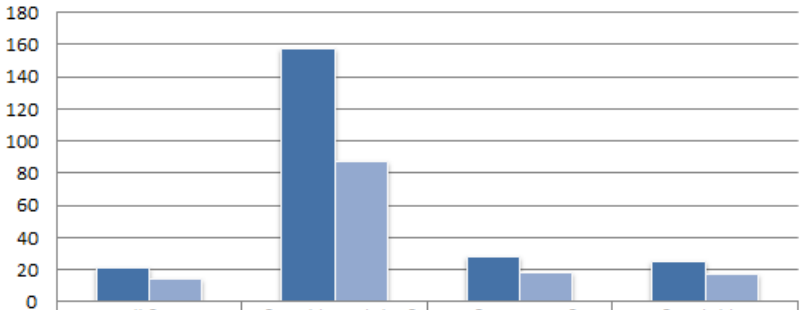
	Argyll & Bute Central	A&B Older Adults & Hospital Services	A&B MH LD & Addiction Services	A&B Children Families & Justice
Total staff	21	158	28	25
Total Complete	12	72	17	15

Safe Information Handling - Foundation



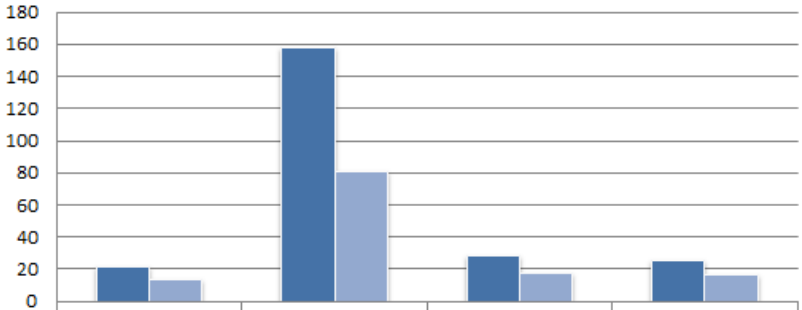
	Argyll & Bute Central	A&B Older Adults & Hospital Services	A&B MH LD & Addiction Services	A&B Children Families & Justice
Total Staff	21	158	28	25
Total Complete	12	72	17	17

Hand Hygiene



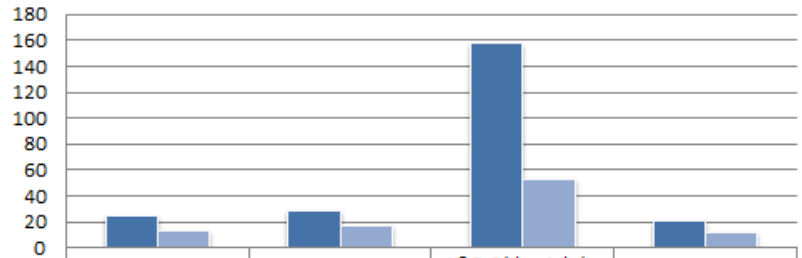
	Argyll & Bute Central	A&B Older Adults & Hospital Services	A&B MH LD & Addiction Services	A&B Children Families & Justice
Total Staff	21	158	28	25
Total Complete	14	87	18	17

Moving and Handling - Module (A)



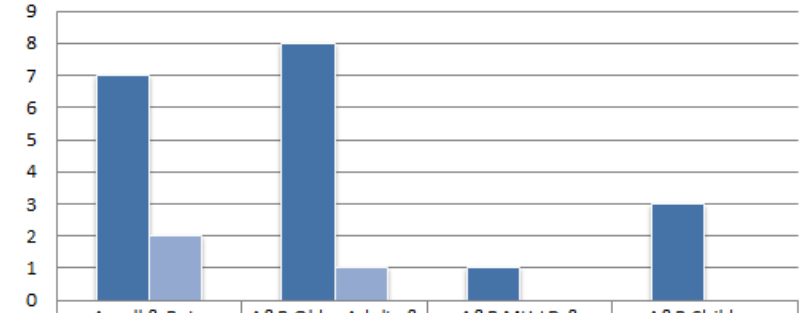
	Argyll & Bute Central	A&B Older Adults & Hospital Services	A&B MH LD & Addiction Services	A&B Children Families & Justice
Total Staff	21	158	28	25
Total Complete	14	81	17	16

Public Protection: Everyone's Responsibility

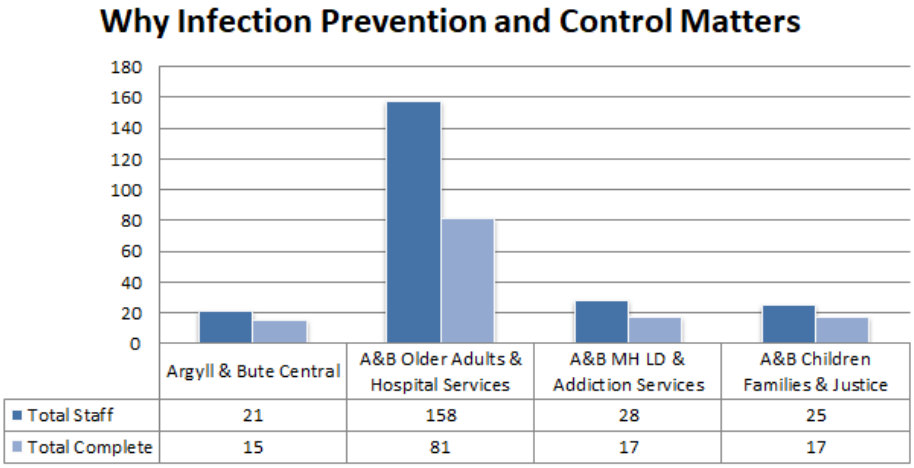


	A&B Children Families & Justice	A&B MH LD & Addiction Services	A&B Older Adults & Hospital Services	Argyll & Bute Central
Total Staff	25	28	158	21
Total Complete	13	17	53	12

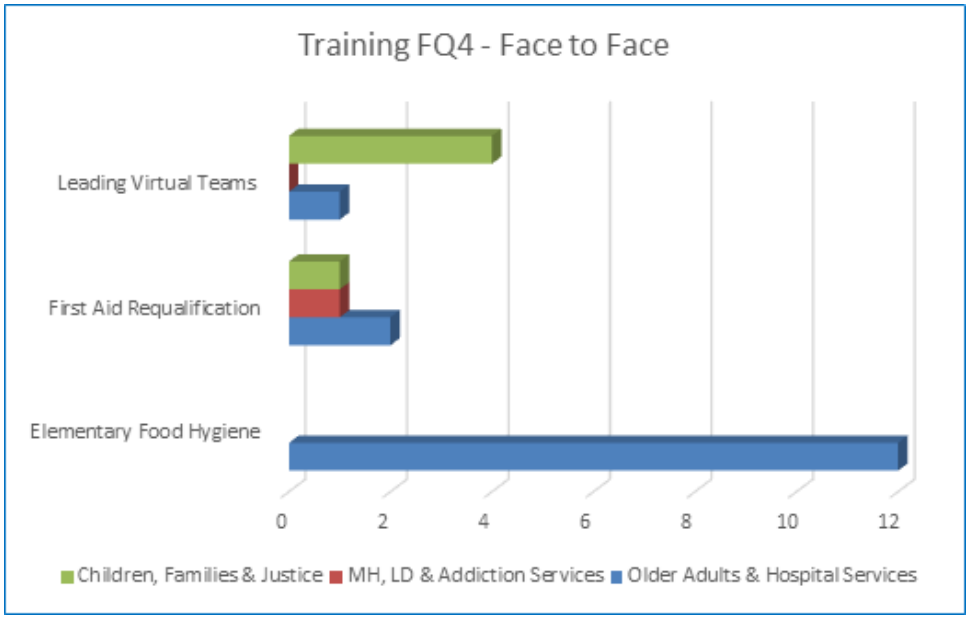
Violence and Aggression (Non-Clinical)



	Argyll & Bute Central	A&B Older Adults & Hospital Services	A&B MH LD & Addiction Services	A&B Children Families & Justice
Total Staff	7	8	1	3
Total Complete	2	1	0	0



Appendix 7 C – Argyll & Bute Council Face to Face and Mandatory Training FQ4



Mandatory course	Number of HSCP employees completed course prior to Q4	As a percentage of the HSCP total workforce	Number completed in FQ 4	As a percentage of the HSCP total workforce who completed in FQ 4
E&D	328	42%	0	0%
Data Protection	671	87%	0	0%
Fire Safety Awareness	571	74%	0	0%
Freedom of information	415	54%	5	1%
PREVENT	221	29%	0	0%
Positive Customer Care	349	45%	1	0%

Whistleblowing Report
Quarter 4 - 1st Jan 2022 to 31st Mar 2022

Guardians / Confidential Contacts
Derek McIlroy and Julie McAndrew

INWO Liaison and Lead Executive
Fiona Hogg

Whistleblowing Champion
Albert Donald

1. Introduction

The National Whistleblowing Standards came into force in Scotland on the 1st April 2021.

The principles have been approved by the Scottish Parliament and underpin how NHS services must approach any concerns which are raised. Every organisation providing a service on behalf of the NHS must follow the standards.

Reports are produced quarterly; this is Quarter 4 (Q4) report. The Quarter 1 report (Q1) provided further detail on legislation, the National Whistleblowing Standards and implementation of these standards in NHS Highland. The Q1 report also provides information on the role of the Confidential Contact.

2. Roles and Responsibilities for National Whistleblowing Standards

Everyone in the organisation has a responsibility under the Standards and we have set out the Board level roles and responsibilities, as a reminder, within NHS Highland in respect of the Whistleblowing Standards. The others are set out in the Q1 report.

NHS Highland Board
The Board plays a critical role in ensuring the standards are adhered to.
Leadership – Setting the tone to encourage speaking up and ensuring concerns are addressed appropriately
Monitoring – through ensuring quarterly reporting is presented and robust challenge and interrogation of this
Overseeing access – ensuring HSCP, third party and independent contractors who provide services can raise concerns, as well as students and volunteers.
Support – providing support to the Whistleblowing champion and to those who raise concerns.

Board Non-Executive Whistleblowing Champion
This role is taken on by **Albert Donald**, who has been in place since February 2020.
The role monitors and supports the effective delivery of the organisation's whistleblowing policy and is predominantly an assurance role which helps NHS boards comply with their responsibilities in relation to whistleblowing. The whistleblowing champion is also expected to raise any issues of concern with the board as appropriate, either in relation to the implementation of the Standards, patterns in reporting of concerns or in relation to specific cases.

INWO Liaison Officer
This role is taken on by **Fiona Hogg, Director of People & Culture**, in her executive lead role in Culture and Communications. This is the main point of contact between the INWO and the organisation, particularly in relation to any concerns that are raised with the INWO. They have overall responsibility for providing the INWO with whistleblowing concern information in an orderly, structured way within requested timescales. They may also provide comments on factual accuracy on behalf of the organisation in response to INWO investigation reports. They are also expected to confirm and provide evidence that INWO recommendations have been implemented.

3. Governance, Decisions and Oversight

The Standards set out the requirement that the NHS Highland Board plays a critical role in ensuring the Whistleblowing Standards are adhered to, including through ensuring quarterly reporting is presented and robust challenge and interrogation of this takes place. In addition, NHS Highland present this report to the Argyll & Bute Integrated Joint Board meeting and the NHS Highland Staff Governance Committee and other management meetings and committees as appropriate. Further information is set out in Section 2 of this report and more details are in Section 5 of the Q1 report.

The Director of People and Culture is the key contact point for oversight of all possible and ongoing Whistleblowing cases for NHS Highland. When the details of a case come through, the Guardian Service, in their role as Confidential Contact (see sections 4 and 5 below and sections 5, 7 and 8 in the Q1 report) contact the Director of People & Culture who reviews the information. NHS Highland have agreed contact points, to input to a decision on whether something is a whistleblowing complaint. This includes senior Operational Leadership (Chief Officers, Senior Management) Professional Leadership (Board Nurse Director, Board Medical Director), Clinical Governance Leads, senior Finance and HR professionals, the Fraud Liaison Officer, Deputy Chief Executive, Chief Executive, and the Head of Occupational Health & Safety. The Guardian Service and Director of People and Culture coordinate this process.

The criteria for the decision are as set out in the National Whistleblowing Standards Definitions: What is whistleblowing? | INWO (spso.org.uk). If the complaint is not Whistleblowing, a response is drafted with clear reasons why it is not Whistleblowing, this is drafted by the Director of People and Culture and sent to the complainant by the Guardian Service, who keep a record of this. If there is another process or route for their concern, this is signposted. This senior level of oversight of the decision making is critical to ensure consistency, compliance with the standards and visibility of concerns. During Q2, one of our decisions was reviewed by the INWO following an appeal and was found to be in line with the Standards.

If the complaint is Whistleblowing, then the Director of People and Culture liaises with relevant senior leadership and contacts to identify a manager to lead on the complaint. The Guardian Service and Director of People and Culture oversee progress, ensure timelines and communications are maintained. The Director of People and Culture will review the outcome and any follow up actions and learnings needed to ensure these are progressed appropriately., with relevant internal and external individuals, bodies, and committees, as appropriate based on the nature of the complaint.

A summary of every closed case in the period will be included in our reports, including any outcome and action taken or planned. Reporting will be limited during the ongoing investigation of a concern.

4. Raising a Whistleblowing Concerns in NHS Highland

Managers and employees can raise a concern:

- through an existing procedure in NHS Highland,
- by contacting their manager, a colleague, or a trade union representative,
- by contacting the "Confidential Contact" via a dedicated email or telephone number.

To date, concerns have been raised directly by individuals or by their trade union representative using both the Guardian email address and the dedicated telephone number for whistleblowing concerns.

An essential aspect of the new Whistleblowing standards is that anyone who provides services for the NHS can raise a concern. This includes current (and former) employees, bank and agency workers, contractors (including third sector providers), trainees and students, volunteers, non-executive directors, and anyone working alongside NHS staff, such as those in health and social care partnerships.

5. The Role of the Guardian Service

Our Confidential Contact role is undertaken by the Guardian Service, on behalf of NHS Highland. The Guardian Service already provide NHS Highland with an independent Speak Up service to raise concerns which has been well utilised by colleagues since launching in August 2020. The independent, dedicated Guardians are well placed to also provide the Confidential Contact role.

The Guardian Service will ensure:

- that the right person within the organisation is made aware of the concern
- that a decision is made by the dedicated officers of NHS Highland and recorded about the status and how it is handled
- that the concern is progressed, escalating if it is not being addressed appropriately
- that the person raising the concern is:
    - kept informed as to how the investigation is progressing
    - advised of any extension to timescales
    - advised of outcome/decision made
    - advised of any further route of appeal to the INWO
- that the information recorded will form part of the quarterly and annual board reporting requirements for NHS Highland.

All Whistleblowing Concerns are recorded by the Guardian Service regardless of who has raised the concern. All concerns are logged to show progress and to measure and track information as required for reporting.

6. KPI Table

The KPI data is taken as at 31st March 2021 for Quarter 4.

KPI	Qtr. 4		YTD	
Concerns Received	1		14	
Concerns confirmed as WB concerns	1	100%	5	35.7%
OPEN Concerns under investigation	2		2	14.3%
Stage 1 concerns closed in full within 5 working days	0		1	100%
Stage 1 concerns closed in full later than 5 working days	0		0	
Stage 2 concerns closed in full within 20 working days	0		0	
Stage 2 concerns closed later than 20 working days	1		2	100%
Stage 2 concerns still open from prior reports	1		1	25%
% of closed calls upheld Stage 1				
% of closed calls partially upheld Stage 1				
% of closed calls not upheld Stage 1			1	8.3%
% of closed calls upheld Stage 2	1	100%	1	8.3%
% of closed calls partially upheld Stage 2				
% of closed calls not upheld Stage 2			1	8.3%
% of closed calls not WB			9	75%
% of closed calls where Whistleblower chose not to pursue.			2	16.7%
% of closed calls which were for another Board to pursue			1	8.3%

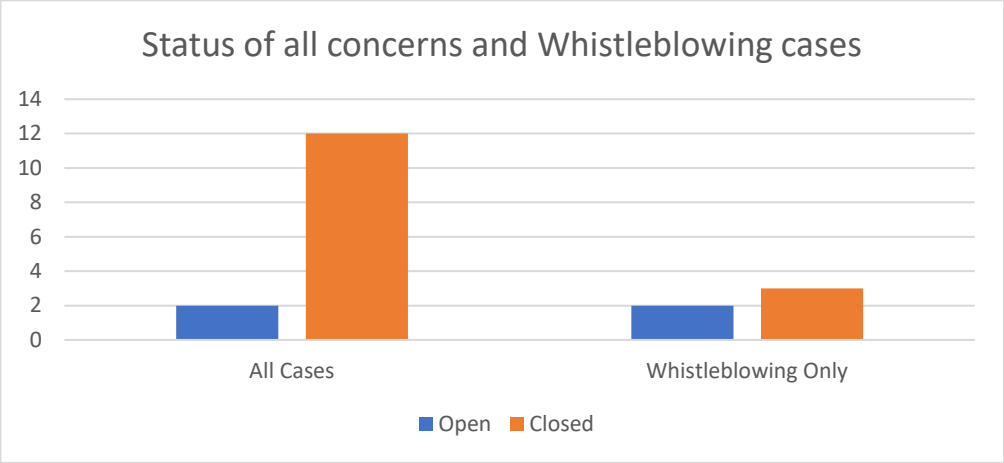
Number of concerns at stage 1 where an extension was authorised as a percentage of all concerns at stage 1	0		0	
Number of concerns at stage 2 where an extension was authorised as a percentage of all concerns at stage 2.	1	100%	4	100%
Number of concerns which weren't Whistleblowing but were passed to Guardian services for resolution (as a percentage of non-Whistleblowing cases raised)	0		1	11.1%

7. Statistical Graphs

The following graphs relate to the Quarter 4 reporting period 1st January 2021 to 31st March 2021. As this is the 4th reporting period and the number of concerns is low, no trend information can be established yet.

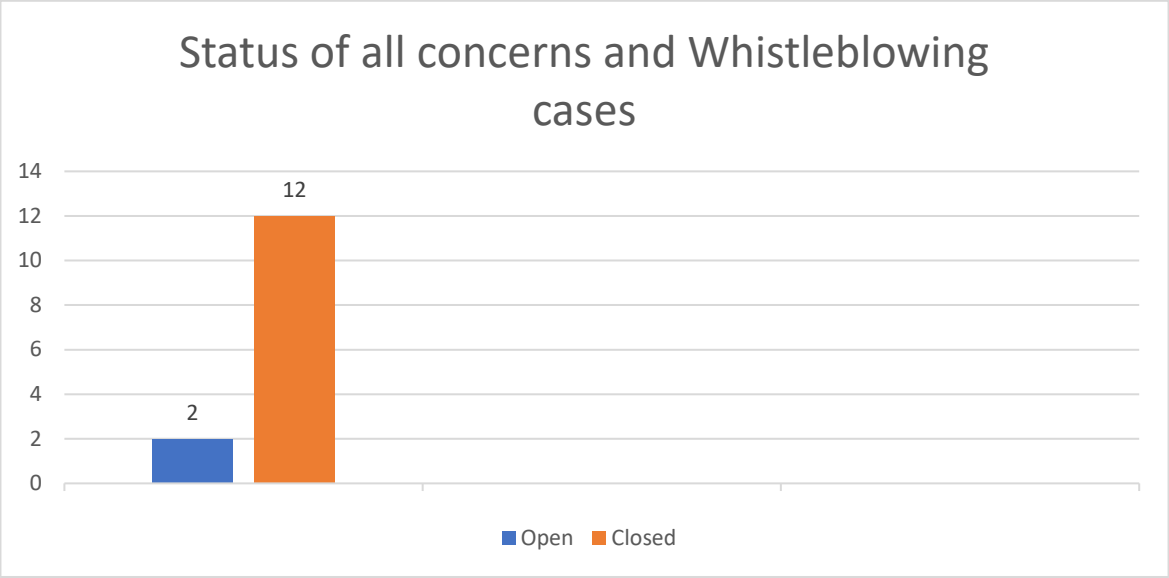
Data has been presented in such a way to ensure that confidentiality is preserved.

Graph 1



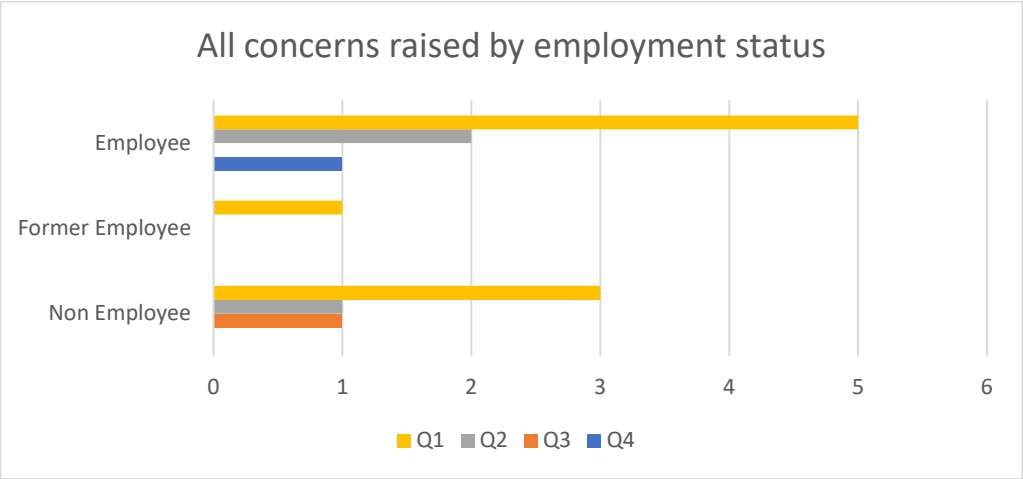
There was one WB concern raised in February 2022 which is report in Q4 and is currently being investigated under stage 2. A concern raised in Q1 and which was investigated under stage 2 was closed in January 2022 and is reported in Q4.

Graph 2

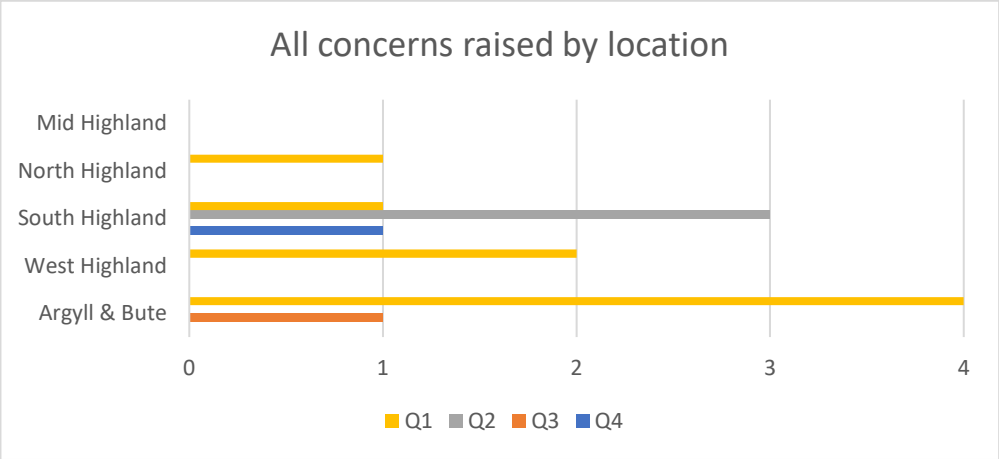


At the end of Q4 there were 2 open cases actively under investigation in accordance with stage 2 of the procedures. One case was from Q3 with appropriate extensions in place for investigation. The other case was raised in Q4 and is under Stage 2 investigation.

Graph 3

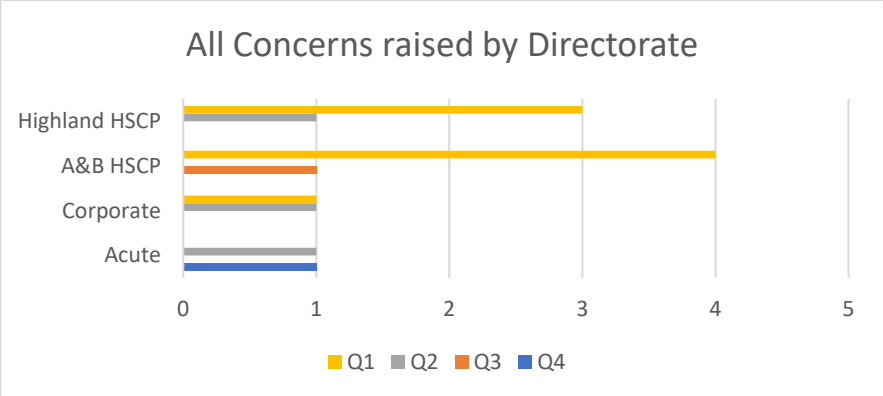


Graph 4



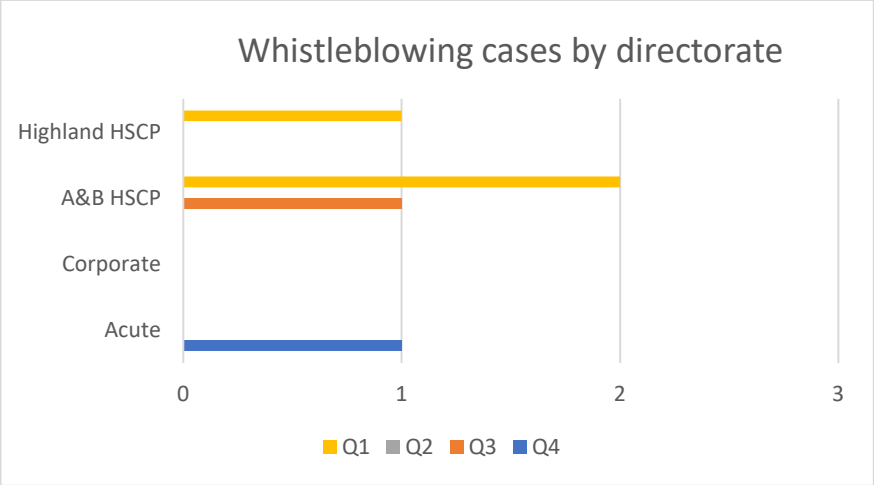
There was 1 additional concern raised in Q1, but this was not related to an NHS Highland service or location, so is not included in this chart.

Graph 5

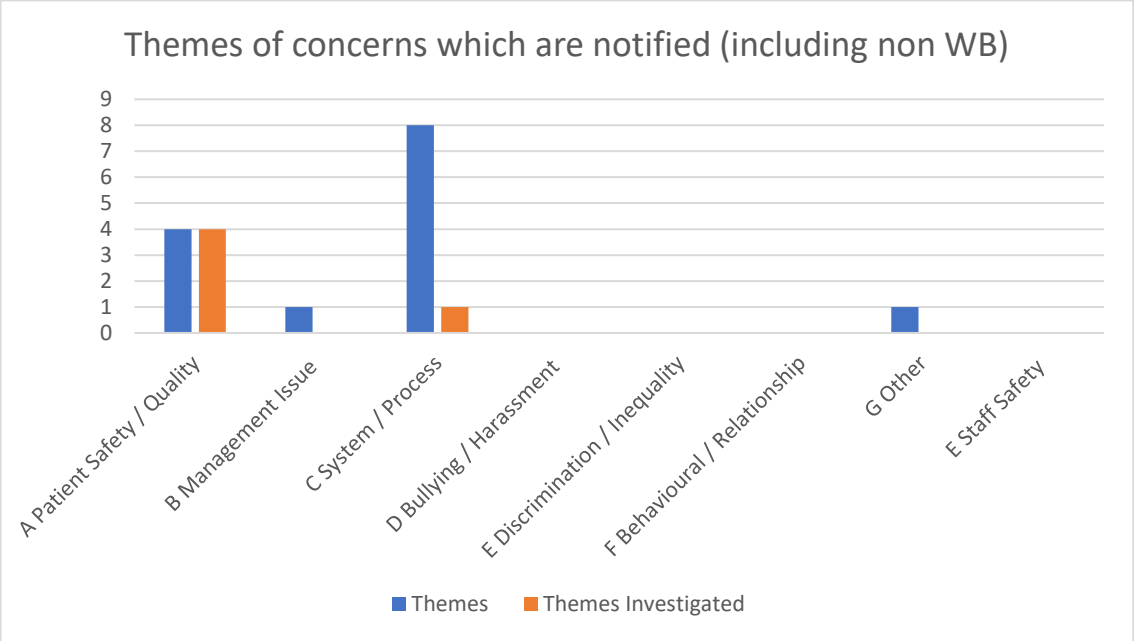


Directorates are used for reporting purposes to preserve the confidentiality of the person raising the concern.

Graph 6



Graph 7



The themes presented in the above chart are the same themes used by the Guardian Service when recording concerns which have been raised by NHS Highland and Argyll & Bute HSCP staff. This will allow an easier comparison of data in the future.

8. Detriment as a result of raising a concern.

There is limited data available but at the point of writing there have been no reports where individuals who have raised whistleblowing concerns reported that they suffered a detriment for doing so.

9. Concerns Received - Average time for a full response

There was one Whistleblowing concerned received this month, which is undergoing a full investigation. There have been three Whistleblowing concerns closed to date, the average time for final response for Stage 1 complaints is 1 day. The average time for Stage 2 complaints is 214.5 days. The overall average time for resolution is 144 days. It is important to note that typically Stage 2 concerns related to substantial reviews into service provision, which impacts on the investigation and completion timescales.

10. Lessons learned, changes to service or improvements

It is anticipated that some further information will be available for the annual report depending on when investigations conclude. The number of Whistleblowing concerns received in the first year have been low with two still under investigation.

11. Staff experience of the Whistleblowing procedures

Proposals of a voluntary staff survey were approved at the implementation group. A version of the survey is still under review and once approved will go out to individuals who have raised concerns through this process. Feedback from this survey will be collated once this process is in place, which will provide data for detailed commentary on staff experiences.

12. Colleague awareness and training

The implementation group continue to meet and review progress with awareness raising and monitoring uptake of training. We will produce an infographic and comms plan as part of the Annual Report process in July 2022, to further promote the standards.

A non-employed partner survey was carried out in December and January which included questions to understand awareness of the standards in those who are not employed by NHS Highland but are covered by the Standards.

72% of the 243 respondents said they were aware of the new Whistleblowing standards and 60% said they agreed that they were clear on their responsibilities under the new standards. 65% were clear on where they could access more information about the standards. This is a positive start, but we will continue to work on improving this.

Our Whistleblowing non-executive Director continues to visit across the Board area and promote his role and speak with colleagues as well as internal and external communications and media. This has been of great value to the Board and has given the Standards good visibility in some of our more remote and rural areas. Reports have been provided on the findings of the visits.

A national review of the training and awareness materials is ongoing and there are proposals to introduce another module for manager awareness. Due to the low number of cases raised, and the senior level these have been managed at, we would expect that those asked to take on an investigation or management role in a case would complete the detailed training ahead of starting their investigation. Promotion of take up of the awareness training to the general manager and colleague population will be the focus.

13. Audit of Whistleblowing Standards Implementation

An internal audit of our implementation of the Whistleblowing Standards was carried out and the report presented to the Audit Committee on 7th December 2021. The report was positive overall and very helpful in focussing our efforts for ongoing improvement.

The recommendations are being implemented and the final ones will be completed by end June 2022, after timescales had to be moved out due to service pressures in Spring. The recommendations are summarised below.

1. Removal of old WB policies and links - Completed
2. Clarification of roles and responsibilities and decision making - Completed Q1 final report
3. Feedback on assurance reporting implemented - Completed Q1 final report
4. Development of Whistleblowing Process document - 30 June 2022
5. Contact details for WB Champion - completed
6. Ongoing refinement of Quarterly reporting format and content - 30 June 2022

14. Summary of Whistleblowing Cases

Quarter 4 Cases

Case 14 OPEN – Patient Safety

This is a stage 2 WB concern where an extension has been authorised beyond 20 days. The concern is actively under investigation. The complaint relates to the impact of poor patient flow on cardiac patient care in an acute hospital. The concerns focused on the lack of available beds resulting in limited access to early specialist care for high-risk cardiac patients. This is being overseen by Dr Robert Cargill, Deputy Medical Director and Kate Patience-Quate, Deputy Nursing Director, supported by Fiona Hogg, Director of People & Culture. A term of reference is currently being finalised. Regular updates are being provided to the complainant.

Quarter 3 Cases

Case 13 OPEN - Patient Safety

This is a stage 2 WB concern where an extension has been authorised beyond 20 days. The concern is actively under investigation with the individual raising the concern kept aware of the investigation process. This complaint relates to provision of services and staffing in a remote location in Argyll & Bute and is being overseen by the Interim Chief Officer for the A&B HSCP, Fiona Davies and the Director of People & Culture, Fiona Hogg. A terms of reference for the review is in place, a working group with the community and key stakeholders has been in place since December 2021 and is meeting regularly to progress the actions. Regular updates are being provided to the complainant.

Cases from Quarter 2

There are no whistleblowing cases ongoing from Quarter 2.

Cases from Quarter 1

Case 1 CLOSED – Patient Safety/Quality

This was a Stage 2 WB concern where an extension was authorised beyond 20 days. This related to some complex and wide-ranging concerns raised about the management and delivery of GP services in a remote and rural location in Argyll & Bute. The complaint was overseen by the Chief Officer, Fiona Davies, and the Director of People & Culture Fiona Hogg, with regular 20-day updates to the complainant throughout.

A full investigation was carried out by the Head of Primary Care for Highland HSCP, and recommendations around management of practices and oversight of Primary Care within Argyll & Bute have been implemented. We have shared the outcomes with the complainant in January 2022 and confirmed that the most urgent actions have been completed. The HSCP are now working through the longer-term actions, overseen by the Area Manager, it was therefore deemed appropriate to conclude the matter as an active WB case in Q4.

Case 2 CLOSED - System Process

This was a Stage 2 WB complaint regarding concerns about health and safety systems and processes in Argyll & Bute. The case was investigated by Bob Summers, Head of Occupational Health and Safety for NHS Highland and his recommendations were reviewed and accepted by George Morrison, Deputy Chief Officer and the case closed in August 2021 following feedback to the complainant.

The complaint was not upheld, as it was found that appropriate systems, processes, and governance were in place. However, it was clear that awareness and understanding of these systems and processes was not as widespread as it should be and a set of actions to improve this were taken forward locally.

Case 9 CLOSED – Patient Safety / Quality

This was a stage 1 complaint and raised in relation to the care of a resident in a care home. The concern was escalated to the Area Manager who actioned the concern and provided feedback to the Guardian. This feedback could not be provided to the caller as they had not provided any contact details and did not call back. The concern was resolved within 2 days.

This page is intentionally left blank

NHS Highland

Meeting:	**Argyll & Bute Integrated Joint Board**
Meeting date:	**25 May 2022**
Title:	**Quarterly Whistleblowing Standards Reporting**
Responsible Executive:	**Fiona Hogg, Director of People & Culture**
Report Author:	**Fiona Hogg, Director of People & Culture**

1 Purpose

This is presented to the Committee for:

- Discussion
- Assurance

This report relates to a:

- Legal requirement

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

This report relates to the following Corporate Objective(s)

Clinical and Care Excellence		**Partners in Care**	
• Improving health		• Working in partnership	
• Keeping you safe	X	• Listening and responding	X
• Innovating our care		• Communicating well	X
A Great Place to Work		**Safe and Sustainable**	
• Growing talent		• Protecting our environment	X
• Leading by example		• In control	X
• Being inclusive		• Well run	X
• Learning from experience	X		
• Improving wellbeing	X		

2 Report summaries

2.1 Situation

Attached is the third Quarterly Whistleblowing Standards report for NHS Highland, covering the period 1 January - 31 March 2022, for review and feedback from the IJB. This will also be presented to the NHS Highland Board meeting on 31 May 2022.

2.2 Background

All NHS Scotland organisations are required to follow the National Whistleblowing Principles and Standards with effect from 1 April 2021. Any organisation providing an NHS service should have procedures in place that enable their staff, students, volunteers, and others delivering health services, to access the National Whistleblowing Standards.

As part of these requirements, a report is required to be presented to the Board on a quarterly basis, as per the extract below from the INWO website. It is also required to present this to the Argyll & Bute IJB on a quarterly basis, in respect of NHS Scotland services delivered by the HSCP on behalf of NHS Highand

*"**Monitoring***

The number of concerns raised by staff will be reported to a public meeting of the board on a quarterly basis. It is the board's responsibility to ensure this reporting is on time and accurate. The analysis should highlight issues that may cut across services and those that can inform wider decision-making. Board members should show interest in what this information is saying about issues in service delivery as well as organisational culture. This may mean on occasions that board members challenge the information being presented or seek additional supporting evidence of outcomes and improvements. They should also explore the reasons behind lower than expected numbers of concerns being raised, based on trend analysis and benchmarking data."

Therefore, NHS Highland will present their monitoring report to the NHS Highland Board and Argyll & Bute IJB on a quarterly basis going forward, following review at the Staff Governance Committee.

2.3 Assessment

The Argyll & Bute IJB plays a critical role in ensuring the Whistleblowing Standards are adhered to in respect of any service delivered on behalf of NHS Highland within Argyll & Bute, including through ensuring quarterly reporting is presented and robust challenge and interrogation of this takes place.

The Guardian Service, as our Whistleblowing Standards confidential contacts carry out the recording and reporting of concerns and possible concerns. Along with the INWO Liaison officer for the Board, Fiona Hogg, the HR Lead, Gaye Boyd and the Whistleblowing Non-Executive Director, Bert Donald, the Guardian Service have compiled the attached report.

Report Development

We are particularly limited in our ability to report on trends or the outcomes of cases at this time, as a result of small numbers of cases, but this will be built into the report as these cases conclude and additional concerns are investigated.

New Cases

We had one new case raised in Q4, relating to concerns over the availability of cardiac beds in an Acute hospital. This is being investigated by senior clinical leadership and a term of reference has been created for approval to allow this to progress. Regular updates to the complainant are being made, in line with the standards.

Ongoing cases

It should be noted that as this is only the fourth period of reporting, and there are only 5 actual Whistleblowing Concerns raised to date, 2 of which are still being investigated and have not concluded, it is not possible to include all the detail that will be expected in future reports. However, both open cases are being led by senior management and being overseen by the Lead Executive. These cases will help to inform future processes, as we build our knowledge and experience in this area.

Concluded Cases

We had one case concluded in Q4, relating to the management of GP services in a specific area of Argyll & Bute. Aspect of the complaint have been upheld and actions proposed in the investigation implemented. A longer-term action plan is underway and is being overseen by the Area Manager and Primary Care leadership.

Internal Audit of Implementation of the Standards

The remaining actions from the Audit have been delayed from March 2022, due to service pressures during the last 3 months, but are on track to complete by end June 2022.

Awareness and Training Progress

Our Whistleblowing Standards Implementation Group, chaired by the Deputy Director of People and which our WB Champion is also a member of, continue to meet monthly with a range of internal and external stakeholders to whom the Standards apply. Focus is on increasing awareness of the Standards and promoting them through communication and engagement.

Annual report

We are also now drafting our annual report, which is additional to the Quarterly reporting, and which will seek to go into more detail about the context and trends and progress with implementation and training. It is also planned to have a short summary or infographic for sharing with colleagues and other stakeholders in an accessible format. This will be presented in the July and August meeting cycle.

Future reporting timescales

The future cycle of reporting is expected to be as follows:

Quarter	Period covered	Staff Governance Committee	NHS Highland Board meeting	Argyll & Bute IJB
Q4 2021/2	1 January - 31 March 2022	4 May 2022	31 May 2022	25 May 2022
Annual report	1 April 2021 - 31 March 2022	6 July 2022	26 July 2022	24 August 2022
Q1 2022/3	1 April - 30 June 2022	7 September 2022	27 September 2022	21 September 2022
Q2 2022/3	1 July - 30 September 2022	9 November 2022	29 November 2022	23 November 2022

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	X
Limited		None	

This report proposes moderate assurance is taken, with the refinement of our processes making good progress. Our outstanding cases are substantial and complex but are being taken seriously and we are working with those involved. However, it is recognised that further work is needed to implement the audit actions, continue with promotion of awareness and training and to ensure cases are progressed in a timely manner.

3 Impact Analysis

3.1 Quality/ Patient Care

The Whistleblowing Standards are designed to support timely and appropriate reporting of concerns in relation to Quality and Patient Care and ensure we take action to address and resolve these.

3.2 Workforce

Our workforce has additional protection in place under these standards.

3.3 Financial

The Whistleblowing Standards also offer another route for addressing allegations of a financial nature.

3.4 Risk Assessment/Management

The risks of the implementation have been assessed and included. Consideration is being given to where this would sit on our operational and board level risks.

3.5 Data Protection

No data protection issues identified.

3.6 Equality and Diversity, including health inequalities

No specific impacts

3.7 Other impacts

None

3.8 Communication, involvement, engagement, and consultation

Duties to involve and engage external stakeholders are carried out where appropriate:

3.8.1 Route to the Meeting

The report is presented for review and feedback and is also presented to the NHS Highland Board on 31 May 2022.

2.4 Recommendation

- **Discussion** – Examine the draft report and consider any additional information or revisions that may be appropriate
- **Assurance** – To give confidence of compliance with legislation, policy, and Board objectives

2.5 Appendices

- Appendix 1 – Whistleblowing Report (Quarter 4 - 1 January - 31 March 2022)

This page is intentionally left blank

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Date of Meeting: 25th May 2022

Title of Report: Health and social care workforce strategy: Three year workforce plan

Presented by: Geraldine Collier

The Board is asked to:

- Note the content of this report, advising the IJB of the HSCP approach to meeting the timeframes of the workforce planning deadlines recently set by Scottish Government
- Take the opportunity to ask questions relating to the content of the report.

1. EXECUTIVE SUMMARY

1.1 This report summarises the requirements pertaining to the development of the HSCP workforce plan which is required by Scottish Government by the 31st July 2022. It reassures the board that the required programme of actions are in place to meet this commitment.

2. INTRODUCTION

2.1 Following the recent publication of the National Workforce Strategy for Health and Social Care and the publication of Scottish Government guidance on the completion of workforce plans, all Boards and HSCP's are required to submit a a draft 3 year workforce plan to Scottish Government by 31st July 2022.

2.2 The strategy sets out the vision for the health and social care workforce and supports the tripartite ambition of recovery, growth and transformation of our workforce and details Strategic actions and commitments that will be taken to achieve this vision and ambition, using a Five Pillars of Workforce strategic framework (Strategy (Plan, Attract, Train, Employ, Nurture).

2.3 The workforce planning guidance, received in April, constitutes the first iteration of new medium term workforce planning guidance for health and social care. It outlines the express intentions of improving the strategic alignment between organisations' workforce, financial and service planning supporting a sustainable social care workforce.

3. DETAIL OF REPORT

3.1 The three Year Workforce Plan required by A&B HSCP, is expected to use the Five Pillars strategic framework outlined within the National

Workforce Strategy) to structure the proposed actions to secure sufficient workforce to meet local projected short-term recovery and medium-term growth requirements across health and social care services.

3.2 It will contain current workforce information and also project what is needed for the future analysing this gap and aligning with medium term planning priorities. There will also be an associated action plan detailing what interventions are needed to fill this gap.

3.3 The time scales set out by Scottish Government are as follows:

- By end July 2022: Three Year Workforce Plans should be submitted in draft to the National Health and Social Care Workforce Plan Programme Office WFPPMO@gov.scot
- By end August 2022: Draft Three Year Workforce Plans will be reviewed and feedback provided by Scottish Government;
- By end October 2022: Three Year Workforce Plans to be published on organisations' websites with electronic side copy to the email link above

3.2. Progress against Scottish Government Time scales

3.2.1 Throughout April there has been work carried out further discussing and capturing the ongoing workforce challenges, building on the information gathered to complete the interim HSCP workforce plan in 2021. . This has involved working across the HSCP (NHS and Council) to identify and shares actions and capture the required data in line with the national guidance.

3.2.2 The month of May will focus on collating the information and compiling a draft plan with relevant discussions with Heads of Service and lead professionals. This will include a facilitated discussion on workforce challenges, risks and mitigations with the SLT on 20th May.

3.2.3 A development session is arranged for IJB on the 15 June where this information will be shared and provides an opportunity for discussion and feedback. After this session all feedback will be incorporated, shared and discussed with SLT and EDG and built into a final draft to be submitted on Scottish Government by the 31st July 2022.

4. RELEVANT DATA AND INDICATORS

4.1 The draft Workforce plan will be furnished with all the relevant data, indicators and trends pertaining to the workforce plan for the HSCP for further scrutiny and discussion.

4.2 For the first time a single workforce dataset for the HSCP will be developed allowing risks across the whole workforce to be mapped and addressed.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

5.1 In a move towards a more integrated approach to workforce planning, the three year workforce plan will detail the workforce actions and risks associated with delivery of the HSCPs joint Strategic Plan.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact

The workforce action plan will detail the costs associated with actions as appropriate

6.2 Staff Governance

Workforce planning actions and data will feature in the Staff Governance reports or more focused workforce planning reports as appropriate.

6.3 Clinical Governance

The workforce planning process and actions will appropriately link to the clinical governance requirements both now and in the future.

7. EQUALITY & DIVERSITY IMPLICATIONS

The 3 year workforce plan and actions plans will be impact assessed in the normal manner.

8. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

Undertaken in compliance with guidance.

9. RISK ASSESSMENT

9.1 Recruitment retention and workforce planning have featured in the audit and risk reports with medium to very high risks, particularly in remote areas. The NHS Scotland audit report identifies that "social care workforce planning has never been more important".

9.2 The 3 year workforce plan and the associated action plans will highlight the priorities and risks with regard to workforce planning.

10. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

Consultation and engagement is key to the workforce planning process. It is vital that senior and middle managers, trade unions, and third and independent sector representatives are involved in the process. The IJB will also be engaged as part of the development session on 15th June.

11. CONCLUSIONS

This paper has sought to provide details of the Scottish Government time frames with regard to HSCP workforce plan and reassure the IJB of the process being undertaken to achieve this ambitious time frame.

12. DIRECTIONS

	Directions to:	tick
Directions required to Council, NHS Board or both.	No Directions required	x
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

REPORT AUTHOR AND CONTACT

Author Name: Geraldine Collier
Email: Geraldine.collier@nhs.scot

This page is intentionally left blank

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Date of Meeting: **25th May 2022**

Title of Report **COVID19 Public Health update**

Presented by: **Dr Nicola Schinaia, Associate Director of Public Health**

The Integrated Joint Board is asked to:

- Consider the COVID19 latest trends in A&B community, in terms of:
  - ◊ Distribution of infection rates;
  - ◊ COVID-19 testing programmes.

- Assess the remobilisation plan following the COVID19 response in A&B community, in terms of Health Improvement.

1. EXECUTIVE SUMMARY

The updates on the COVID-19 Public Health response in Argyll and Bute and focus on two main areas:

- Sustained community transmission has considerably reduced in the last 5-6 weeks. Many social distancing measures are in place only as recommendations, not mandated any longer.
- Testing for SARS-CoV-2 in Argyll and Bute – widespread community testing has ceased, and access to routine testing is mainly for health and social care staff and patients prior to admission to various health care services, in accordance to the transition plan that was briefly mentioned in our previous report (end-March 2022).

As a consequence of this improved picture, Public Health programmes prior to the onset of the Covid-19 pandemic are resuming in earnest.

2. INTRODUCTION

This paper builds on accounts provided in the earlier reports, and will present the timeliest update as possible of how the pandemic is unfolding in A&B, as well as how the next phase of the pandemic response in Scotland will be developing.

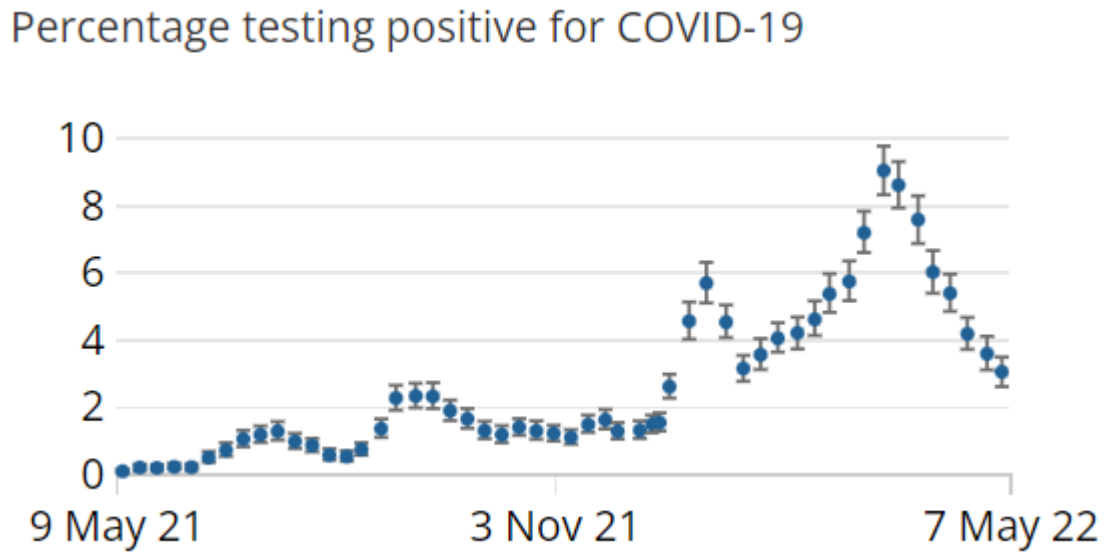
A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

3. DETAIL OF REPORT

A. Epidemiology of COVID-19 in Argyll and Bute (as reported up to 13th May 2022)

- The Office for National Statistics (ONS) infection survey (Figure 1) shows that the proportion of people in the community with COVID-19 has decreased since a high in the week of 13th to 19th March to the most recent timepoint available at writing (1st to 7th May). The survey is based on testing of a sample of individuals and it is not affected by changes in access to testing.

Figure 1. ONS infection survey results – Scotland weekly modelled estimates – up to 1st to 7th May 2022



Source:
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/coronaviruscovid19infectionsurveypilot/18march2022

- 7-day rates of confirmed cases have decreased in Argyll and Bute (appendix 1). This likely reflects both changes in access to testing as well as decreased rates of infection. There were a recorded 132.3 cases per 100,000 population confirmed by a test between 7th and 13th May.
- Over 8% of the recent cases in NHS Highland are identified as reinfections (that occurred 90 days or more following a previous COVID-19 infection).

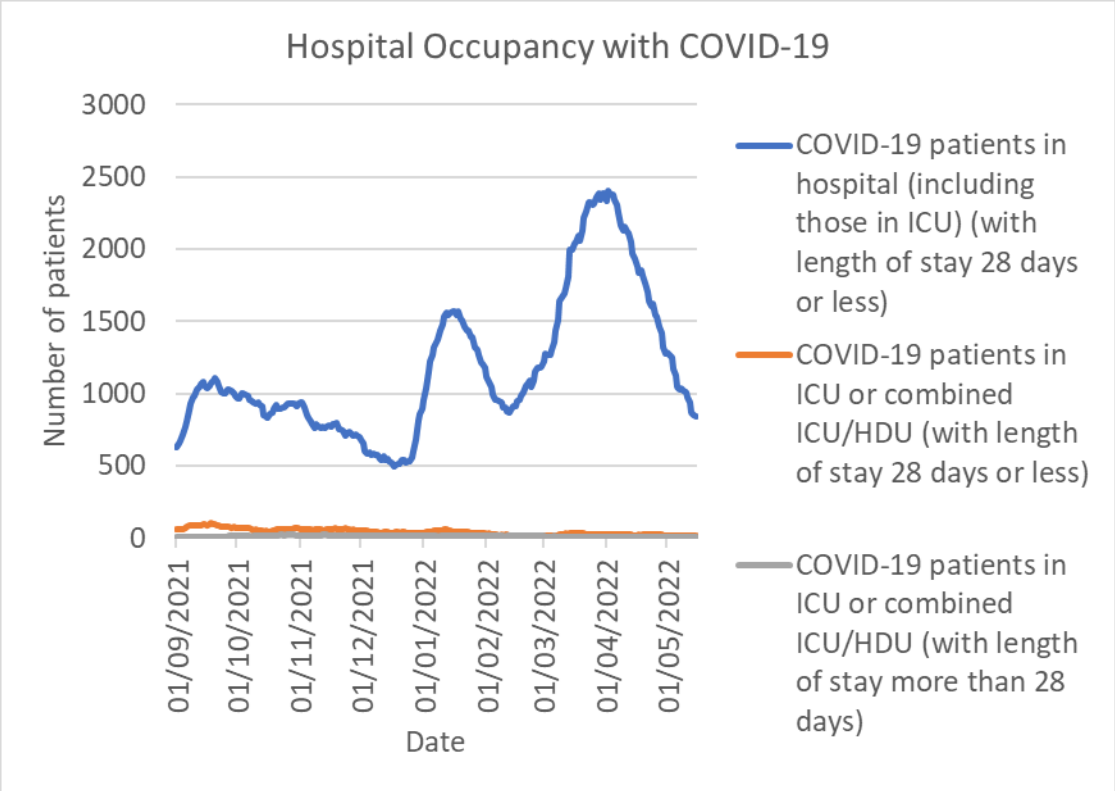
See Appendix 1 for embedded NHS Highland Epidemiological Briefing.

- The number of people in hospital *with* COVID-19 has decreased since a peak in April 2022 (Figure 2).

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

- ICU numbers have also decrease with 17 people in ICU with COVID-19 (at 15th May 2022). Note that these figures include people in hospital for reasons other than COVID-19.

Figure 2. Number of people in hospital with COVID-19 in Scotland



Source: https://www.opendata.nhs.scot/dataset/covid-19-in-scotland

- Recent modelling highlights the continued uncertainty regarding future COVID-19 infections.

https://www.gov.scot/collections/coronavirus-covid-19-modelling-the-epidemic/

B. COVID-19 Testing in Argyll and Bute

B1 Lateral Flow Device Testing For Health and Social Care Staff

Origins

In December 2020 the Scottish Government directed Health Boards and Health and Social Care Partnerships to implement the roll out of Lateral Flow Device (LFD) testing in patient facing staff within Healthcare, Social Care and Primary Care. Over the following months this offer of voluntary twice weekly testing was extended to include all Healthcare staff, specific Social Care roles, contractors of registered services and some other services. The programme is managed across NHS Highland, with 4 main workstreams: Raigmore, New Craigs, North Highland Community Services, and Argyll and Bute.

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Delivery and Supply

The delivery and supply pathways have evolved since the initial rollout of the testing programme. National Services for Scotland (NSS) supply all pathways from a central hub. The LFD product for the foreseeable future will be Orient Gene 7s.

Healthcare Pathway: UPDATE In this pathway test kits are delivered to Lochgilphead for onward distribution to all hospitals in Argyll and Bute. Work is underway to create a supply route locally utilising PECOS.

Social Care Pathway: National Services Scotland (NSS) supply PPE hubs with LFD testing kits using a push allocation and resupply. Social Care staff collect test kits from their local PPE hub.

- Volumes requested suggest most staff are continuing to participate in LFD testing.
- There have been regular changes to staff groups included in LFD testing, hubs have continued to communicate changes and adapt which staff groups receive kits.

Primary Care Pathway: Primary Care partners are provided kits by a push allocation and resupply from NSS. NSS indicated that a push allocation would be used for reissue of kits in this pathway. Push allocations from August 2021 will supply Orient Gene 7s.

Process & Reporting of Results

Symptomatic staff were previously asked to take a PCR test, they are now advised to take an LFD test as soon as they feel unwell and report the results to their line manager. In the event of any positive test staff should not attend work for 5 full days and can return to work following 2 consecutive negative LFD test results taken at least 24 hours apart. Full details on changes to the LFD testing programme were released via a Directors Letter issued on 29 April 2022 which can be accessed at: https://www.sehd.scot.nhs.uk/dl/DL(2022)12.pdf

Healthcare, Social Care and Primary Care staff should record every test result onto the Covid Testing Portal. Results were used to initiate contact tracing, from 1 May 2022 all contact tracing of staff ended in line with ending it for the general population.

Conclusion

Improvement calls between NHS Highland and the Scottish Government were ceased due to the quality of the improvement plan submitted in May 2021. There are no plans at present to reintroduce these calls.

LFD testing remains an important tool in the identification of COVID infection. Continued twice weekly LFD testing is strongly encouraged for all eligible staff. The eligible cohort of this pathway will be kept under clinical review nationally with any changes communicated to stakeholders.

B2 Community Testing

Community asymptomatic testing for the public has been in place since April 2021 in Argyll and Bute in response to a Scottish Government request to expand access to rapid Lateral Flow Device (LFD) testing for the public. The service was successfully deployed by Live Argyll in Argyll and Bute. A static testing site was established in Helensburgh with pop-up sites throughout Argyll and Bute the locations of which were driven by data and health intelligence. After a successful and innovative pilot of assertive delivery and collect during COP26, the service moved away from supported testing to LFD collect and an assertive delivery model. This move was fully endorsed by the Scottish Government.

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

In March 2022, the Scottish Government announced the cessation of community asymptomatic testing from the 18th April and subsequent cessation of testing for the public from the 1st May 2022.
Work commenced to wind up the service and move to evaluate the local response to the unprecedented public health challenge and examine lessons learned in preparation for any future step up of service required in the future. A plan to formally evaluate the asymptomatic community testing programme had been formulated in late summer of 2021 with ethical approval gained early in 2022 providing the opportunity to publish a research paper. Significant progress has been achieved in the delivery of the evaluation with the first milestone being the presentation of the interim evaluation results at the Faculty of Public Health Conference in May 2022. The final report will be available from mid-June 2022.

C. Health Improvement in Argyll and Bute

The past two years has seen constant flux between proactive health improvement delivery and the Covid-19 response. However, there is now an ongoing rebalancing, with health improvement core business once again being the primary focus of the team. Health improvement is defined as the prevention of health problems and improving health outcomes across the population. This is often achieved through an inequalities lens by targeting those most in need. Health improvement considers the causes of ill-health, then develops interventions and programmes to address these root causes. Argyll and Bute HSCP has a small health improvement workforce, however, by building capacity through the Living Well Networks, communities, partners and across the wider health and social care system, manages to deliver a wide ranging operation plan.

The pandemic brought significant impacts on health and wellbeing; some of these impacts are manifesting now but many will manifest over the life-course. National and local Public Health leadership recognises the importance of tailoring appropriate responses. The following are the key health improvement programmes in Argyll and Bute:

- **Living Well Strategy**

The Living Well Strategy 2019-2024 was endorsed by the IJB in September 2019. It provides a framework for preventing the occurrence of long term conditions (LTCs) as well as enabling those living with an LTC to maximise their health. The key components of this strategy include: people have the tools and support to enable them to live well; a wide range of local services to enable people to live well; staff motivated to enable people to live well; and effective leadership to deliver Living Well intentions. An active multi-disciplinary steering group oversees the delivery of an annual action plan. Current highlights include:

- **Mental Health Engagement**

Jean's Bothy, Support in Mind Scotland and ACUMEN were commissioned to engage with residents of Argyll and Bute to explore the impact of the pandemic on mental wellbeing and access to support during 2021. A report is being developed documenting: participants' experiences of accessing community and peer support, experiences of accessing statutory support, and the impact of the pandemic on

mental wellbeing. Findings will be shared with Living Well Networks, the Living Well Steering Group and Community Planning groups. An event is being planned for Summer 2022 where recommendations arising from the report will be discussed and next steps agreed.

- **Physical Activity Sub Group**

This group promotes and increases opportunities and levels of engagement for adults within Argyll and Bute to access physical activity and exercise regardless of current physical ability or level of frailty. Work includes supporting education of staff and the public on the significant risks of sedentary behaviour and the positive impacts in general wellbeing, aging well and in the prevention and management of illness and mental health. Key partnerships exist with Versus Arthritis, Live Argyll and Macmillan Cancer Support.

- **Community Links Workers and Social Prescribing**

Social prescribing means connecting people with sources of support for potential causes of their health problems: for example, money worries, loneliness, being an unpaid carer or a relationship breakdown. All staff working directly with people should be able to take a person centred approach to providing holistic care. The General Medical Services Modernisation Programme recognised the potential for social prescribing to improve primary care, which includes the provision of Community Link Working (CLW) service. CLW will be delivered in a targeted way via prioritised GP practices through the provider We Are With You. Community Link Workers were appointed in late 2021 and are now in the process of launching services across Argyll and Bute. Referral to the CLW is via the wider GP Practice team.

Further information on Living Well in Argyll and Bute is available here - Living Well Strategy — Living Well (squarespace.com)

- **Social Mitigation Strategy**

NHS Highland Board ratified the Social Mitigation Strategy in May 2021 in recognition of the increased demands for services and the need to do things differently. This strategy includes a range of priorities based on the analysis of the impacts of the pandemic with a focus on poverty/cost of living, mental health and wellbeing. The impact of cost of living increases cannot be underestimated and is a key priority in Argyll and Bute's health improvement plan.

- **Money Talks**

Money Counts level 1 awareness training is delivered in Argyll and Bute to inform front line staff of how they can support the people they work with, who are experiencing money worries. The session increases the understanding of poverty, its impact and increases knowledge of support services for money matters. Four sessions have already been delivered with two more confirmed in May and June.

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

- **Poverty**

Living in poverty is strongly associated with negative health outcomes. The Health Improvement Team works with partners on a range of responses to mitigating the impacts of poverty. One example of this is the Child Poverty Action Plan which is a statutory requirement for all local authorities in Scotland. Other examples include fuel poverty, food insecurity and digital inclusion activity. The Living Well Networks meetings have all had speakers presenting on challenging poverty in Argyll and Bute.

- **Community Planning**

The Health Improvement Team takes an active role in the Community Planning Partnership (CPP), both in local authority wide activity and in the four local area groups. Examples include:

- **Climate Change**

A Climate Change strategic group convened in 2021 to oversee an area wide response to addressing climate change and the impact on our communities. A draft action plan includes: engaging people on developing and implementing the plan; taking action to adapt how we live to reduce carbon emissions; and mitigate the impacts of climate change in local communities. The group is in the process of maximising resources to employ a project officer.

- **Suicide Prevention**

Suicide prevention is led by the HSCP on behalf of the wider CPP. There is an active multi-disciplinary steering group tasked with delivering a local action plan. Priorities in this plan include: access to support for those impacted by suicide; distress brief intervention and psychological first aid; digital support; and use of/sharing of data and information to improve suicide prevention intervention. These priorities were set by Cosla in 2020. The Scottish Government ran a consultation earlier in 2022 for the next iteration of a national policy on suicide prevention.

- **Shaping Places** in Dunoon

There are six national Public Health priorities for Scotland[1] including, *a Scotland where we live in vibrant, healthy and safe places and communities*. The Improvement Service in partnership with Public Health Scotland have developed a place based approach called 'Shaping Places'. Dunoon is one of the six towns selected for this project, which aims to inform national approaches for place based working.

National Health Improvement Outcome Framework from Scottish Government

Approximately 40% of the budget associated with public health activity in Argyll and Bute is ring fenced. This includes Outcomes Framework funding for smoking cessation, healthy weight and sexual health activity, which is awarded on an annual

[1] Scotland's public health priorities - gov.scot (www.gov.scot)

basis with some specific targets. The HSCP reports on the outputs of this work via the Annual Performance Report.

The smoking cessation service continued throughout the pandemic through virtual consultations and the Smoking Cessation Advisers are now moving back to face to face working.

A steering group oversees all healthy weight activity, which is led by Dietetics service. Additional funding is awarded to address type 2 Diabetes.

Sexual health outcomes relate to prevention and health improvement activity rather than service delivery. There is an ongoing third sector service level agreement in place across NHS Highland.

4. RELEVANT DATA AND INDICATORS

Data have been reported in the above section and in the Appendices. In summary, we have presented trends on: confirmed cases of COVID-19 infection, overall and COVID-19-specific mortality.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

This work supports/underpins the HSCPs strategic and operational response to this emergency pandemic.

6. GOVERNANCE IMPLICATIONS

Financial Impact

These activities - responding to the pandemic and following on from it - have employed a larger number of resources, primarily in terms of person-time, than budgeted for the year. Such increased spending has been tagged to dedicated COVID-19 funding and will be accounted under this budget line.

Staff Governance

The workforce consequences and staff and TU fantastic response to the crisis has epitomised the adoption and strengthening of good communication and formal engagement processes and partnership working.

Clinical Governance

Clinical governance response has been fundamental to the shaping and management of the public health projections and demand modelling and our response to ensure patient, client and staff safety.

7. PROFESSIONAL ADVISORY

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Inputs from professionals across stakeholders remain instrumental in the response to the COVID19 pandemic. There has been a close collaborative working between the Departments of Public Health in Argyll and Bute and North Highland. We expect this to be a long-lasting positive outcome of this major incident.

8. EQUALITY & DIVERSITY IMPLICATIONS

Equality and diversity is being reviewed and considered as we progress through this pandemic cycle and emergency operating arrangements. It has already been extensively shown that marginalised communities fare worst in relation to both infection rates and health outcomes. An impact assessment will be developed for the response in due course, but in the meantime principles of equality have informed specific programmes of activity. Examples of this include targeted activity with gypsy/traveller communities and developing communications materials for different audiences e.g. learning disability friendly and subtitles for people with hearing impairment.

9. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

Compliance with GDPR remains critical and is being considered within the various pieces of work supporting the sharing of information and data to protect health and wellbeing of staff and the public and patients.

10. RISK ASSESSMENT

Not required for this report.

11. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

A comprehensive communications strategy exists to provide accurate information on the COVID-19 response to staff, partners and the wider population. The Third Sector Interface contributes to the Caring for People Tactical Partnership and provides a link to local community resilience activity, third sector organisations and community members.

12. CONCLUSION

It would appear that Public health – as much of most of other health services – can resume a wider set of activities than during the acute stage if the pandemic response.

DIRECTIONS

	Directions to:	tick
Directions required to Council, NHS Board or both.	No Directions required	
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

REPORT AUTHOR AND CONTACT

Author Name Nicola Schinaia, Associate Director of Public Health
Email nicola.schinaia@nhs.scot

Appendix 1

NHS Highland Epidemiology Briefing (12th May 2022)

COVID-19 Epidemiology Report

NHS Highland Public Health Intelligence Team

12 May, 2022

1 Introduction

From the 1st of May 2022, national testing policy (https://www.gov.scot/publications/test-protect-transition-plan/) for COVID-19 changes from population level symptomatic testing to targeted testing for clinical care and high risk settings. As a consequence, Public Health Scotland (PHS) caution that 'the quantity and quality (https://publichealthscotland.scot/news/2022/may/update-to-reporting-of-covid-19-statistics/) of the data available to report on COVID-19 is increasingly limited' for the purposes of population surveillance.

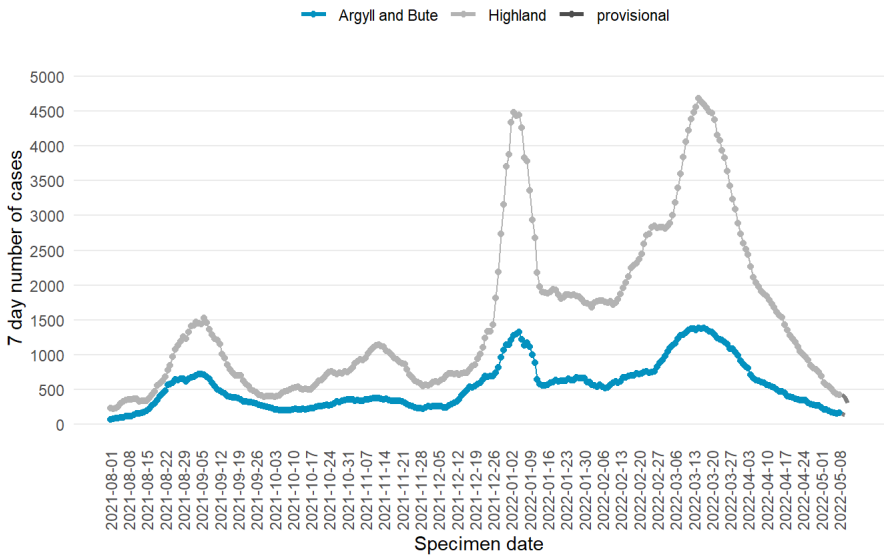
Moving forward, targeted testing will remain an important component of wider surveillance of COVID-19. The content and frequency of this publication will therefore be reviewed over the coming weeks.

Note that from the 5th of January 2022 the national case definition includes cases identified by either PCR test, LFD test, or both.

- Cases are assigned to geographies using the postcode recorded at the time of testing or, if that is not available, by the postcode of the usual residence derived from the Community Health Index database.
- The time necessary to process and submit testing data means that tests carried out in the most recent two to three days will be incomplete.
- The seven-day figures in the report are presented with a lag to try and ensure that a complete period of data are provided.

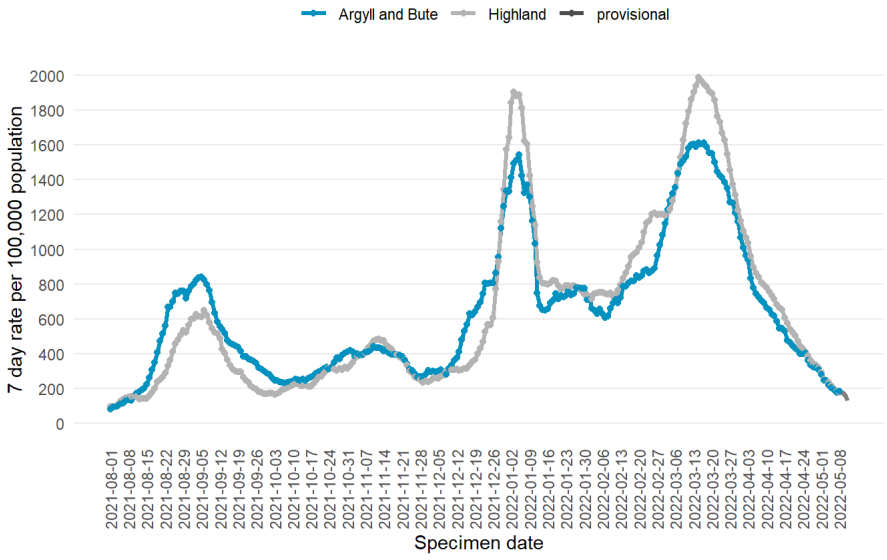
2 **Trends**

Figure 1: Number of cases over seven days



Data source: NSS Test and Protect Data Virtualisation layer, NHS Highland data warehouse

Figure 2: Rate per 100,000 population over seven days

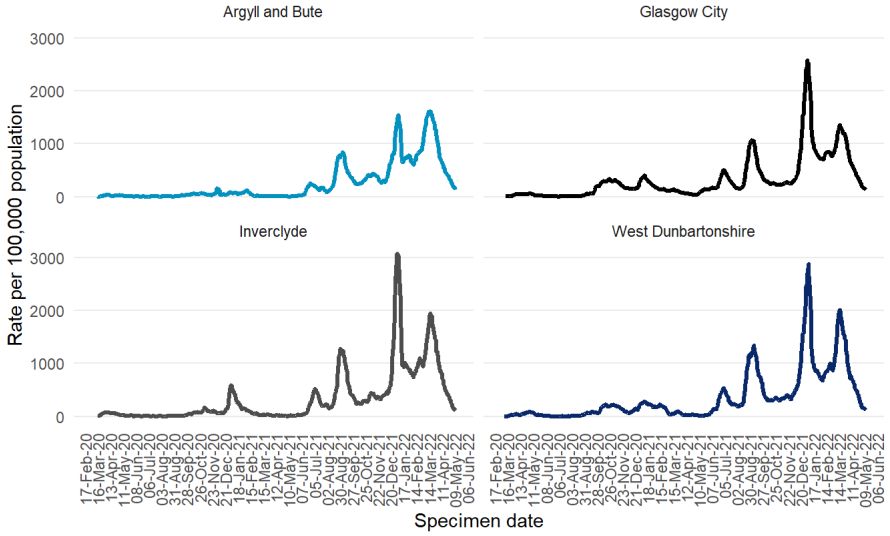


Data source: NSS Test and Protect Data Virtualisation layer, NHS Highland data warehouse

2.0.1 **Local Authorities**

Figure 3: Rate per 100,000 over seven days - Argyll & Bute

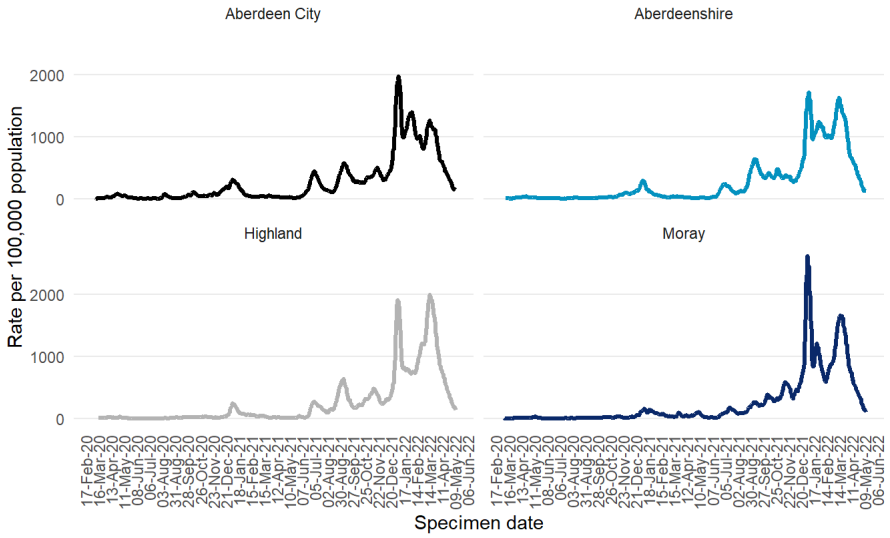
Comparison with selected neighbouring Local Authorities



Data source: Public Health Scotland Daily, COVID-19 Cases in Scotland (Open Data)

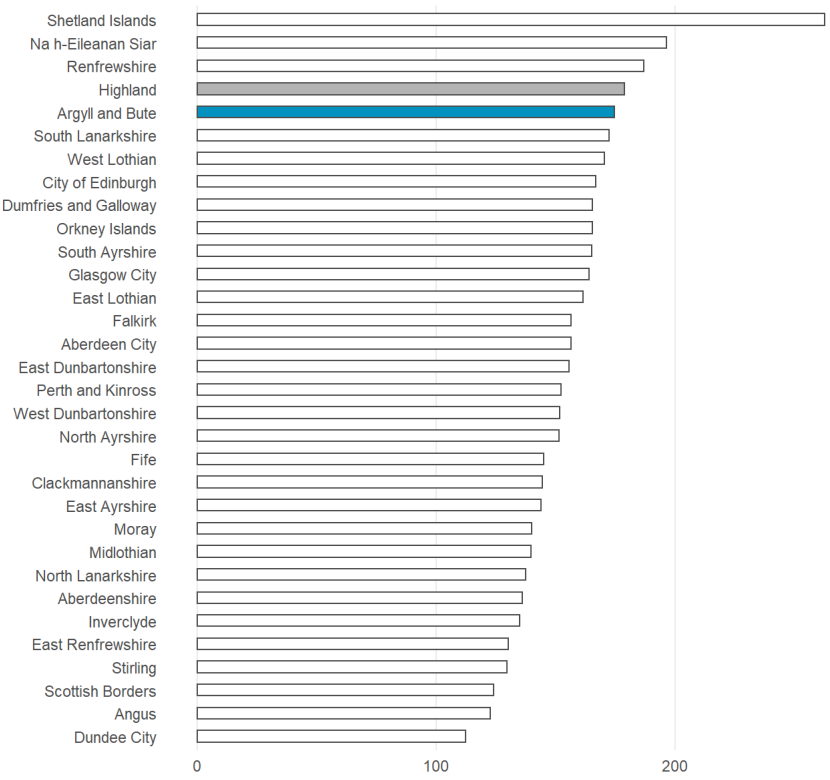
Figure 4: Rate per 100,000 over seven days - Highland

Comparison with selected neighbouring Local Authorities



Data source: Public Health Scotland Daily, COVID-19 Cases in Scotland (Open Data)

Figure 5: 7 day rate per 100,000, week ending 09 May, 2022

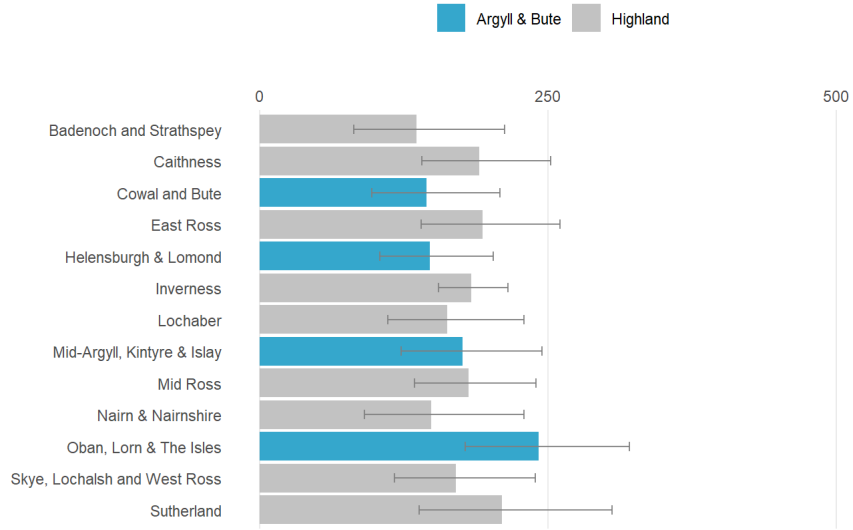


Data source: Public Health Scotland Daily, COVID-19 Cases in Scotland (Open Data)

2.0.2 **Localities and Community Partnerships**

Figure 6: Rate per 100,000 population in the most recent week

03 May, 2022 to 09 May, 2022



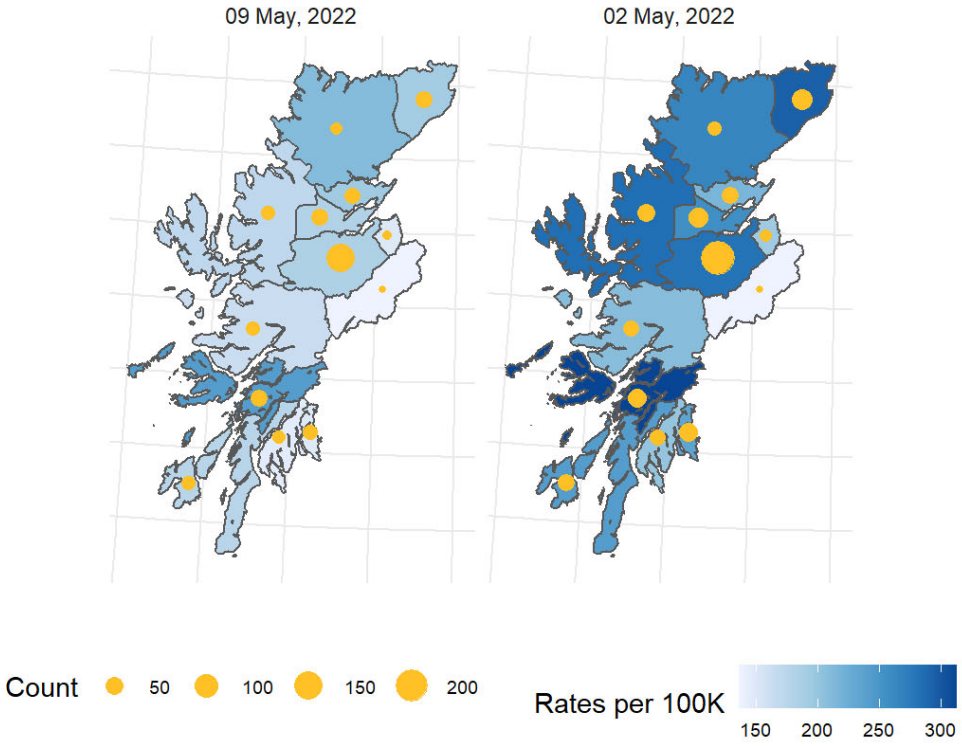
Data source: NSS Test and Protect Data Virtualisation layer, NHS Highland data warehouse

Figure 7: Cases in the most recent week (w/e 09 May, 2022) compared to the previous week (w/e 02 May, 2022)

Council	Locality / Community Partnership	Recent Week Cases	Previous Week Cases	Difference	Recent Week Rate per 100,000 population	Previous Week Rate per 100,000 population
▼ Argyll & Bute (4)		150	210	-60	175.6	245.8
	Cowal and Bute	29	40	-11	145	200
	Helensburgh & Lomond	38	60	-22	148	233
	Mid-Argyll, Kintyre & Islay	35	48	-13	176	242
	Oban, Lorn & The Isles	48	62	-14	242	312
▼ Highland (9)		421	595	-174	178.8	252.7
	Badenoch and Strathspey	19	19	0	136	136
	Caithness	48	74	-26	191	294
	East Ross	43	48	-5	194	216
	Inverness	150	229	-79	184	280
	Lochaber	32	41	-9	163	208
	Mid Ross	49	69	-20	181	256
	Nairn & Nairnshire	20	26	-6	149	193
	Skye, Lochalsh and West Ross	33	55	-22	170	284
	Sutherland	27	34	-7	210	265

Figure 8: Maps of cases in the most recent 2 weeks

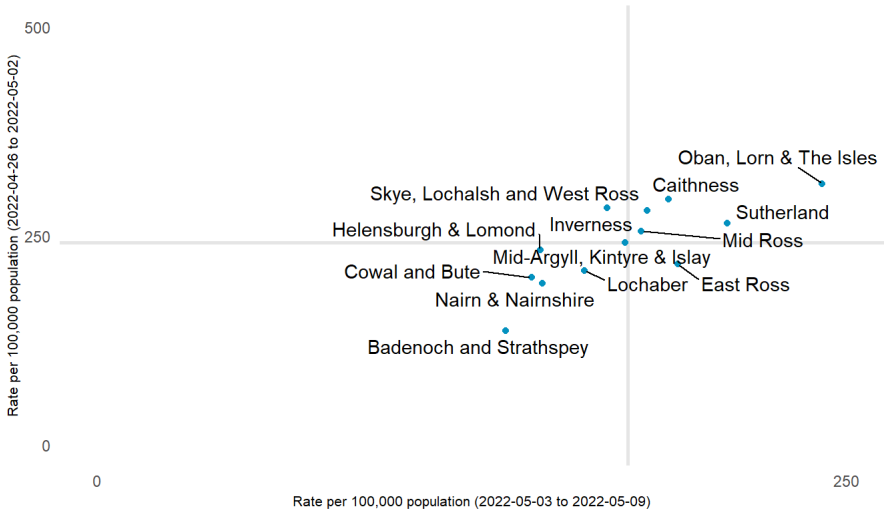
Week ending 09 May 2022 compared to the previous week ending 02 May 2022



Data source: NSS Test and Protect Data Virtualisation layer, NHS Highland data warehouse

Figure 9: Scatter plot of rate per 100,000 population

Week ending 09 May 2022, compared to the previous week, Week ending 02 May 2022

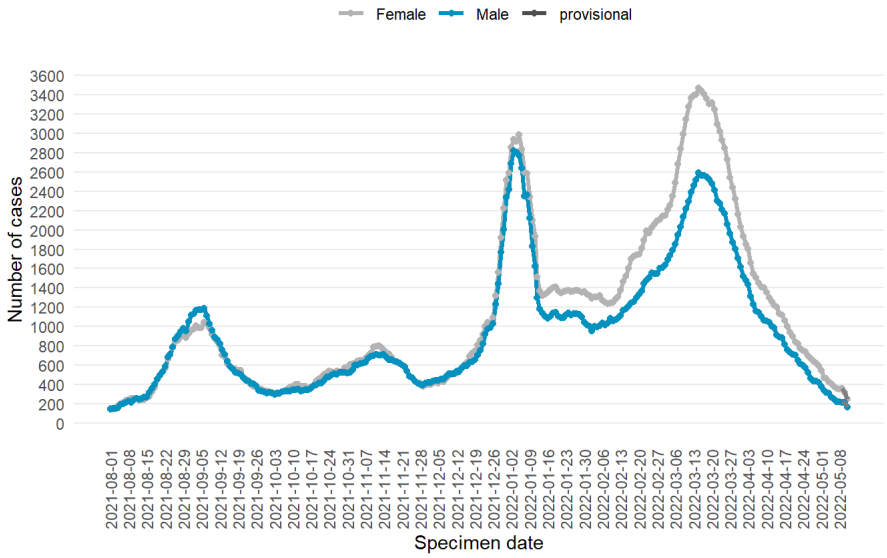


Data source: NSS Test and Protect Data Virtualisation layer, NHS Highland data warehouse

Grey lines represent the weekly median rates

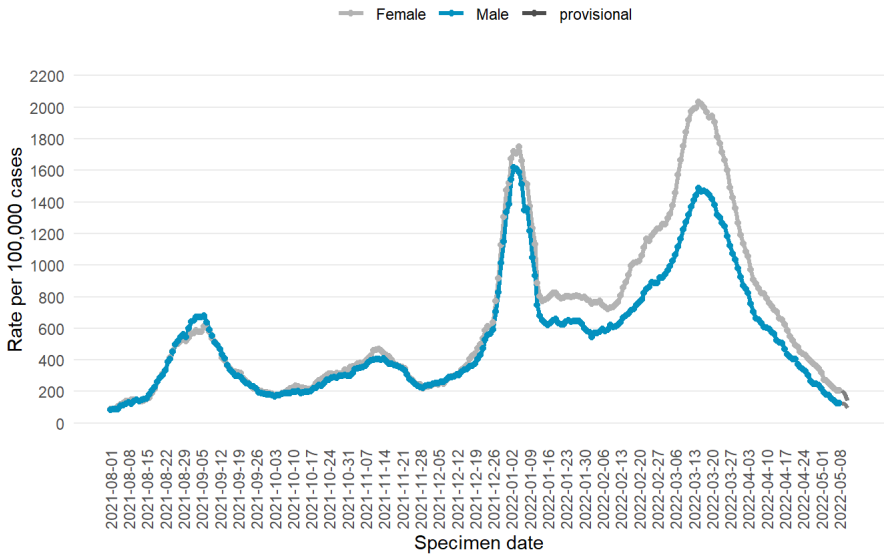
3 **Age and gender**

Figure 10: Number of cases over seven days by gender, NHS Highland



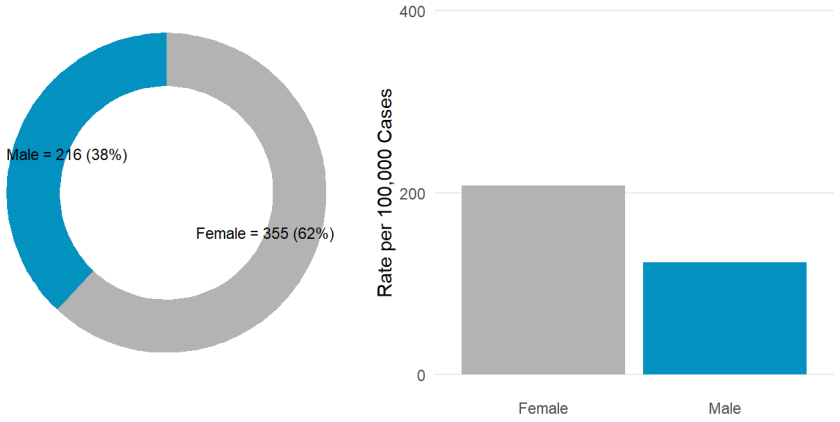
Data source: NSS Test and Protect Data Virtualisation layer, NHS Highland data warehouse

Figure 11: Rate per 100,000 population over seven days by gender, NHS Highland



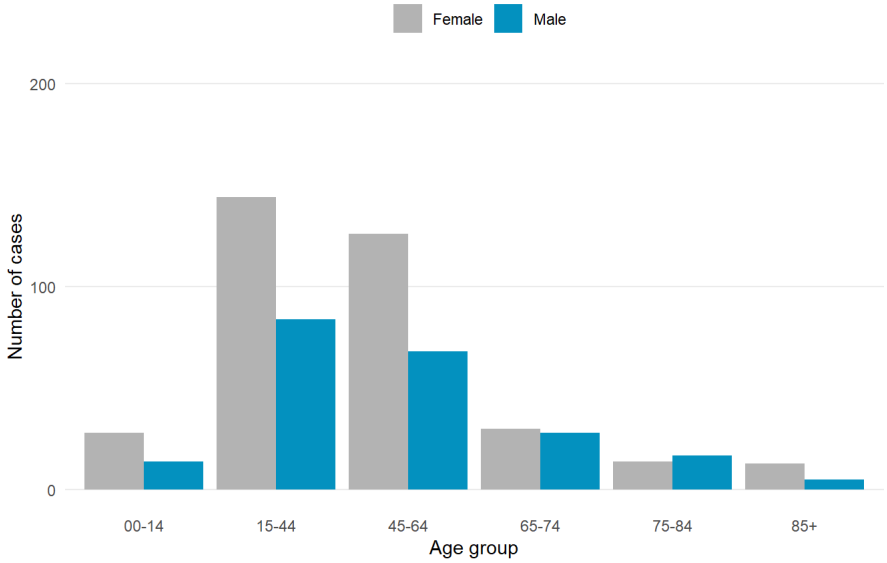
Data source: NSS Test and Protect Data Virtualisation layer, NHS Highland data warehouse

Figure 12: Cases in the most recent week by gender, NHS Highland



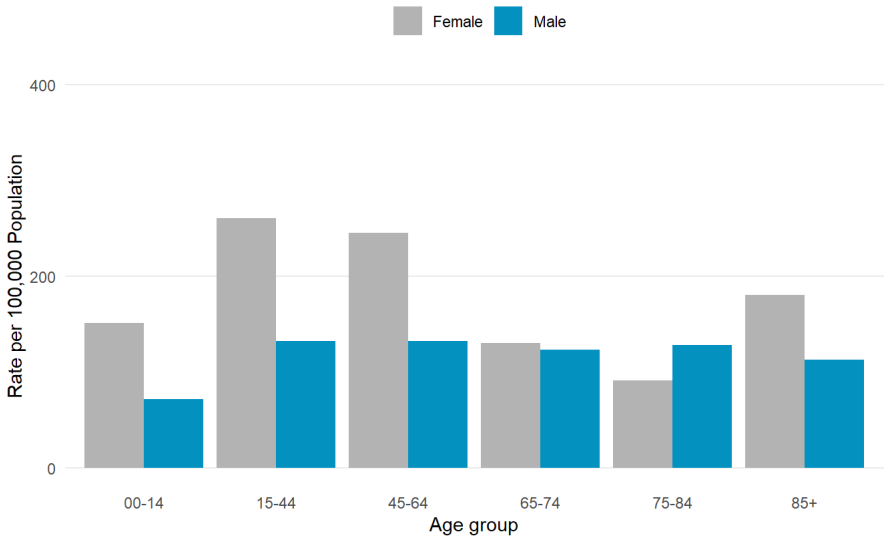
Data source: NSS Test and Protect Data Virtualisation layer, NHS Highland data warehouse

Figure 13: Number of cases in the most recent week, by age, NHS Highland



Data source: NSS Test and Protect Data Virtualisation layer, NHS Highland data warehouse

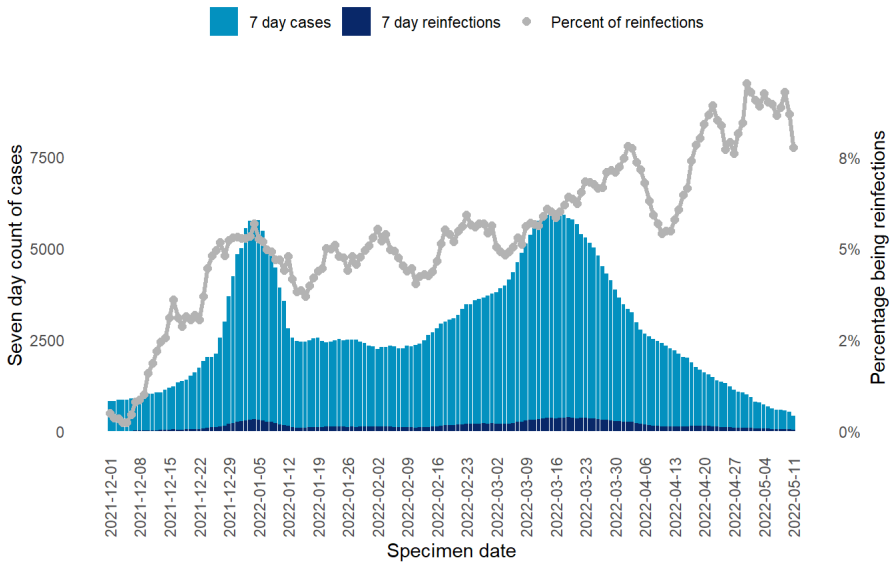
Figure 14: Rate per 100,000 in the most recent week, by age, NHS Highland



Data source: NSS Test and Protect Data Virtualisation layer, NHS Highland data warehouse

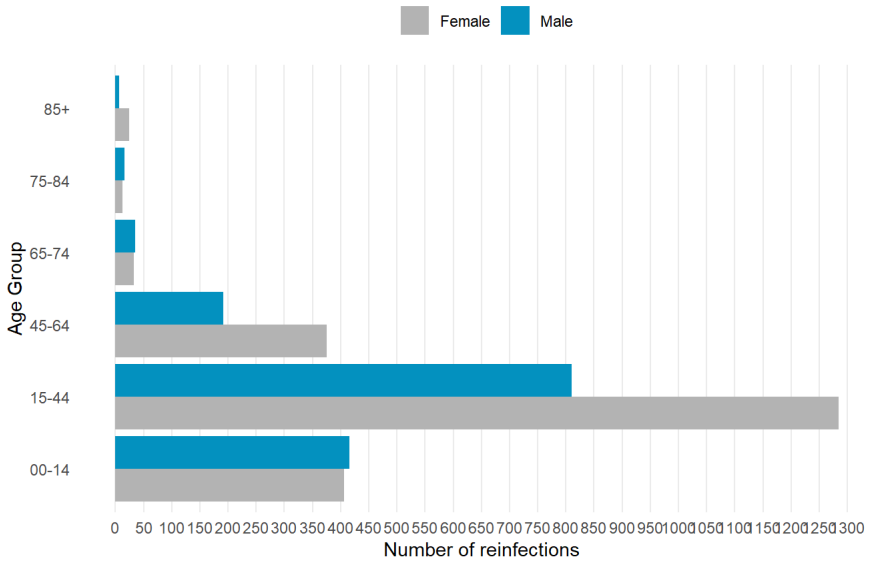
4 **Episode of infection**

Figure 15: Cases over seven days by episode and reinfection rate, NHS Highland



Data source: NSS Test and Protect Data Virtualisation layer, NHS Highland data warehouse

Figure 16: Number of reinfections by age and gender from 1 Dec 2021, NHS Highland



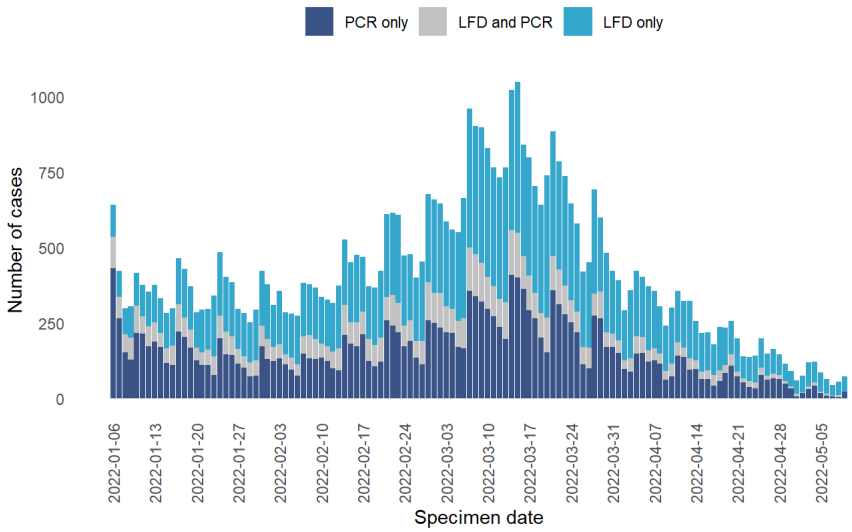
Data source: NSS Test and Protect Data Virtualisation layer, NHS Highland data warehouse

Figure 17: Rates of reinfection in Localities and Community Partnerships from 1 December 2021

Council ↑	Locality / Community Partnership ↑	Reinfection Rate per 100,000 population
▼ Argyll & Bute (4)		1,231.4
	Cowal and Bute	1 050
	Helensburgh & Lomond	1 819
	Mid-Argyll, Kintyre & Islay	558
	Oban, Lorn & The Isles	1 325
▼ Highland (9)		1,086.5
	Badenoch and Strathspey	1 010
	Caithness	698
	East Ross	1 202
	Inverness	1 485
	Lochaber	1 082
	Mid Ross	1 181
	Nairn & Nairnshire	691
	Skye, Lochalsh and West Ross	391
	Sutherland	459

5 **Test type**

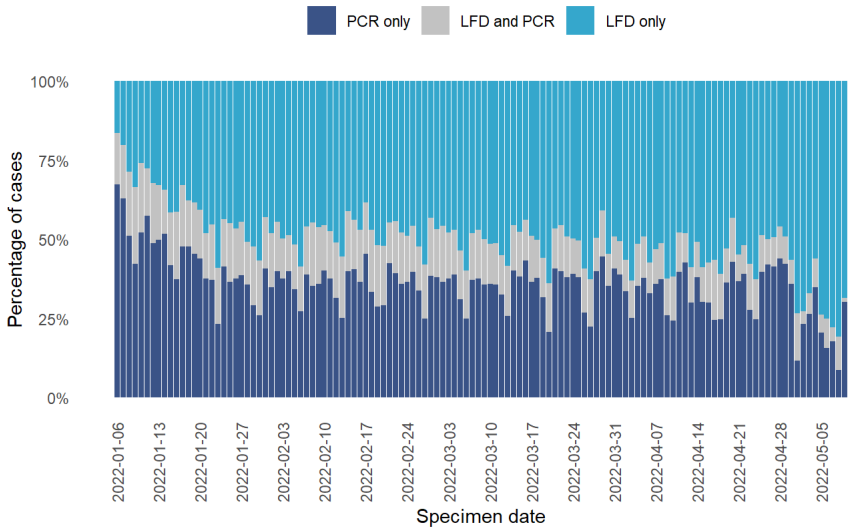
Figure 18: Number of cases by test type, NHS Highland



Data source: NSS Test and Protect Data Virtualisation layer, NHS Highland data warehouse.

Cases can move between the categories as testing is completed, but are only counted once.

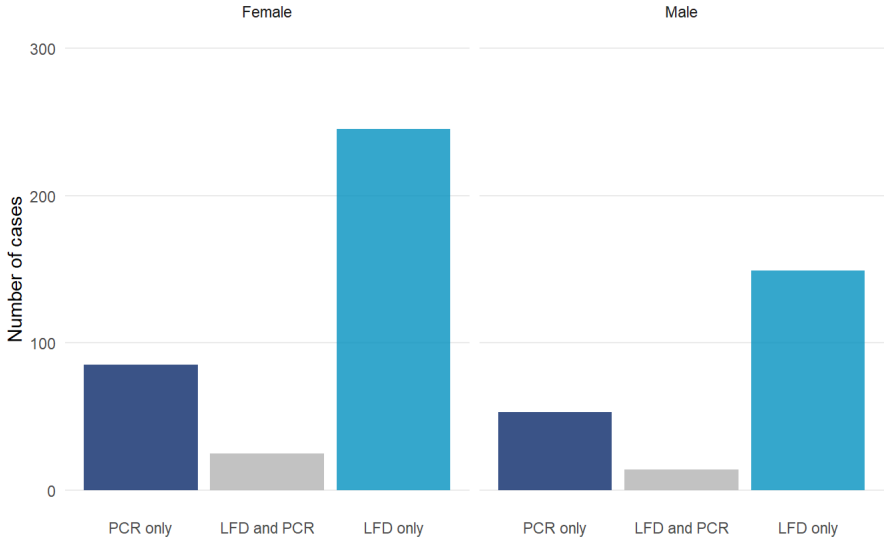
Figure 19: Percentage of cases by test type, NHS Highland



Data source: NSS Test and Protect Data Virtualisation layer, NHS Highland data warehouse.

Cases can move between the categories as testing is completed, but are only counted once.

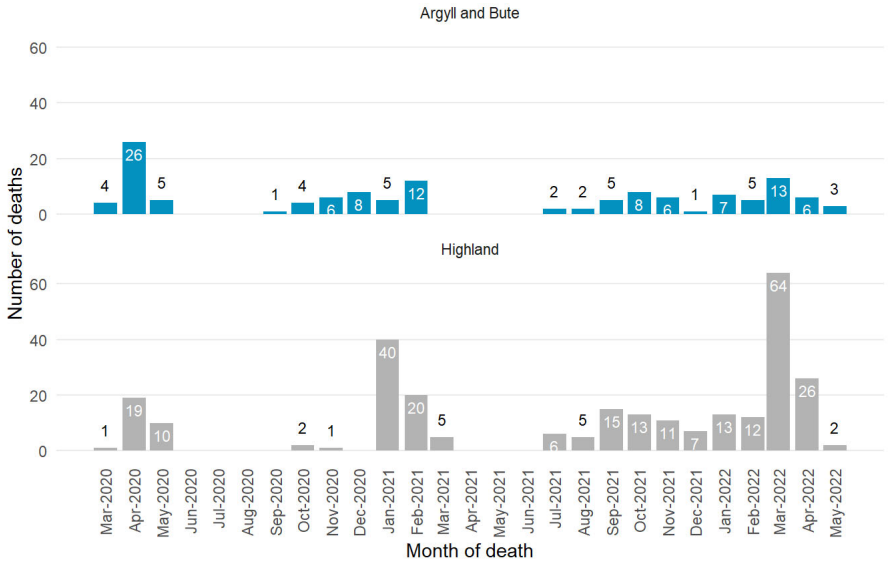
Figure 20: Number of cases by test type and gender, NHS Highland



Data source: NSS Test and Protect Data Virtualisation layer, NHS Highland data warehouse

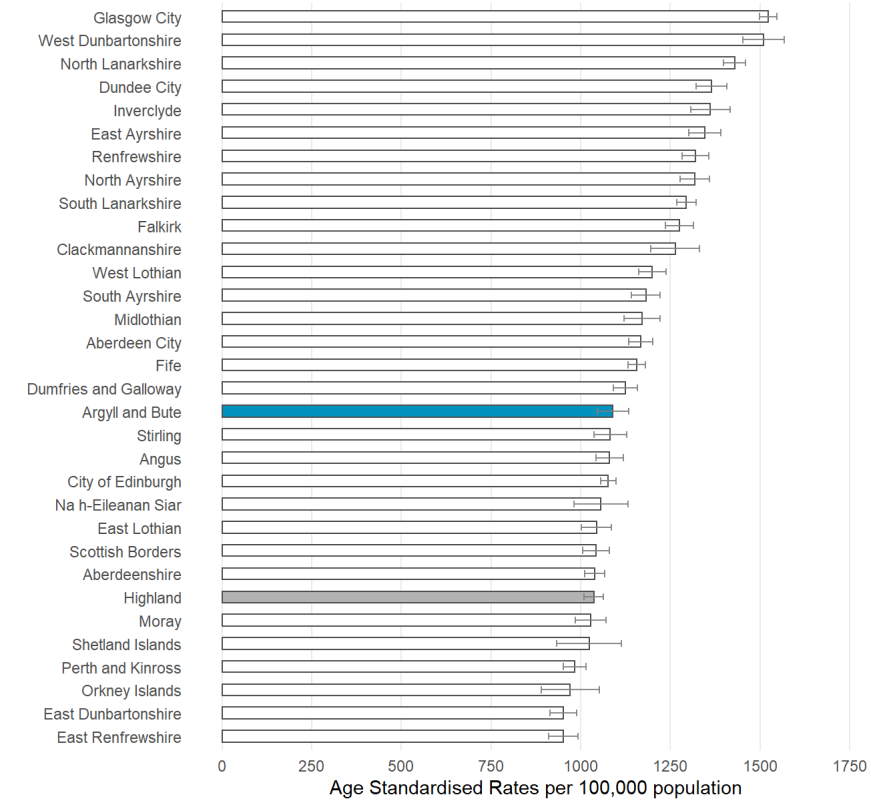
6 **Deaths**

Figure 21: Number of deaths (COVID-19 confirmed)



Data source: Public Health Scotland Daily, COVID-19 Cases in Scotland (Open Data)

Figure 22: Age standardised rates for deaths involving COVID-19
Scottish Local Authorities from 1 March 2020 to 31 December 2021



Data source: National Records of Scotland, Deaths involving COVID-19

7 **Additional information**

ONS Coronavirus (COVID-19) Infection survey (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/coronaviruscovid19infectionsurveypilot/latest), containing high level estimates for England, Wales, Northern Ireland and Scotland

Public Health Scotland COVID-19 daily cases in Scotland dashboard (https://publichealthscotland.scot/our-areas-of-work/covid-19/covid-19-data-and-intelligence/covid-19-daily-cases-in-scotland-dashboard/overview-of-the-daily-covid-19-data-dashboard/) (updated Monday to Friday) with the latest available figures on Coronavirus (COVID-19) in Scotland (positive cases number of tests carried out, deaths of people with a positive test, COVID-19 vaccination rates)

Public Health Scotland COVID-19 & Winter Statistical Report (weekly) (https://publichealthscotland.scot/publications/show-all-releases?id=20580) draws sights from a wider range of existing metrics around COVID-19 and winter pressures

ONS Coronavirus (COVID-19) Infection Survey (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/coronaviruscovid19infectionsurveycharacteristicsof associated-with-testing-positive-uk), characteristics of people testing positive for COVID-19

Modelling the COVID-19 epidemic in Scotland (weekly) (https://www.gov.scot/collections/coronavirus-covid-19-modelling-the-epidemic/) including the spread of the disease through the population (epidemiological modelling) and the demands it will place on the system

Coronavirus (COVID-19): state of the epidemic in Scotland (weekly) () brings together different sources of evidence and data about the coronavirus epidemic to summarise the current situation

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Integration Joint Board **Agenda item: 11**

Date of Meeting: 25 May 2022

Title of Report: Integration Joint Board- Performance Report (May 2022)

Presented by: Stephen Whiston - Head of Strategic Planning, Performance & Technology

The Integrated Joint Board is asked to:

- Consider the HSCP performance progress regarding remobilisation of activity in line with NHS Highland performance target for 2021/22 agreed with Scottish Government to 70%-80% of 2019/20 activity as at November 2021
- Consider Waiting Times Performance and a further reduction in Consultant and Nurse Led Outpatient breaches >12 weeks
- Acknowledge performance with regards to both Argyll & Bute and Greater Glasgow and Clyde current Treatment Time Guarantee for Inpatient/Day Case Waiting List and activity
- Note future performance reporting arrangements relating to the HSCP's Integrated Performance Management Framework
- Note Scottish Government's advice on timescales for the publication of 2021/22 Annual Performance Report (APR).

1. EXECUTIVE SUMMARY

The remobilisation of services across both health and social care is a Scottish Government priority and frontline staff and managers are working hard to achieve this across the Health & Social Care Partnership. This report therefore provides the IJB with an update on the impact on service performance and the progress made with regard to remobilising health and social care services in Argyll & Bute up to 31st March 2022. IJB are also asked to note future performance reporting arrangements associated with the development and roll out of the HSCP's Integrated Performance Management Framework, and also Scottish Government's advice on timescales for the publication of 2021/22 Annual Performance Report (APR).

2. INTRODUCTION

NHS Highland's (NHSH) Remobilisation plan focuses on the areas agreed as priorities with the Scottish Government and includes information on 10 work streams and associated projects. Alongside this the Framework for Clinical Prioritisation has been established to support Health Boards with prioritising service provision and framing the remobilisation of services against 6 key principles within a Covid19 operating environment as below:

*1. **The establishment of a clinical priority matrix** – as detailed below, at the present time NHSGG&C & NHS Highland are focusing on the P1 & P2 category:*

- *Priority level 1a Emergency and 1b Urgent – operation needed within 24 hours*
- *Priority level 2 Surgery/Treatment – scheduled within 4 weeks*
- *Priority level 3 Surgery/Treatment – scheduled within 12 weeks*
- *Priority level 4 Surgery/Treatment – may be safely scheduled after 12 weeks.*

NHS Boards can decide to pause non urgent or elective services (P3 & P4) to ensure they retain capacity to cope with Covid19 emergency need and NHS Highland implemented this in August at Raigmore.

*2. **Protection of essential services** (including critical care capacity, maternity, emergency services, mental health provision and vital cancer services)*

*3. **Active waiting list management** (Consistent application of Active Clinical Referral Triage (ACRT) and key indicators for active waiting list management, including addressing demand and capacity issues for each priority level)*

*4. **Realistic medicine remaining at the core** (application of realistic medicine, incorporating the six key principles)*

*5. **Review of long waiting patients** (long waits are actively reviewed (particularly priority level four patients)*

*6. **Patient Communication** (patients should be communicated with effectively ensuring they have updated information around their treatment and care)*

3. DETAIL OF REPORT

The report details performance for March 2022 with regards to the Health & Social Care Partnership, NHS Greater Glasgow & Clyde and NHS Highland.

4. RELEVANT DATA & INDICATORS

4.1 Remobilisation Performance

The tracker below summarises the HSCP service remobilisation performance against agreed SGHD target (70-80%) for April 2021 to March 2022

HSCP Remobilisation Tracker April 2021 to March 2022

A&B HSCP - Remobilisation Plan Tracker

Key Performance Indicators		Performance Overview													Cumulative Apr 2021 - Mar 2022	
Description		Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Target	Total
Ref	**TTG**															
TTG 1	TTG Inpatient & Day Case Activity (All Elective	44	34	36	39	41	36	35	24	36	37	35	49	41	528	443
Ref	**REFERRALS**															
R-1	Total Outpatient Referrals	803	807	780	846	705	780	706	818	798	667	691	729	997	9636	9324
R-2	Total Urgent Suspicion of Cancer Referrals Received	28	47	26	58	47	45	46	44	43	44	29	42	55	336	526
	OUT PATIENTS															
OP-1	Total New OP Activity Monitoring	652	602	685	723	630	682	668	642	810	525	600	661	634	7824	7862
OP-2	Total Return OP Activity Monitoring	904	1319	1286	1454	1424	1446	1459	1479	1631	1233	1419	1425	1526	10848	17101
OP-3	Total AHP New OP Activity Plan	556	889	926	1020	874	964	953	893	992	818	849	894	1066	6672	11138
OP-4	Total AHP Return OP Activity Plan	1312	2660	2691	2821	2368	2619	2549	2343	2527	2087	2014	2033	2455	15744	29167
Ref	**DIAGNOSTICS**															
DI-1	Total Endoscopy Activity Monitoring	50	67	88	66	58	65	61	63	62	55	15	52	51	600	703
DI-2	Total Radiology Activity Monitoring	462	485	509	581	560	503	508	468	528	463	410	469	699	5544	6183
Ref	**CANCER**															
CA-1	Total 31 Days Cancer - First Treatment Monitoring	9	3	4	7	10	2	4	3	1	4	3	4	3	108	48
Ref	**UNSCHEDULED CARE**															
UC-1	Total A&E Attendances Monitoring (LIH)	685	552	729	812	786	813	745	660	598	591	622	608	759	8220	8275
UC-2	Total A&E Attendance (AB Community Hospitals)	1244	1880	2152	2234	2276	1986	2190	1882	1882	1823	1793	1741	2022	14928	23861
UC-3	Total % A&E 4 Hr (LIH)	95%	98%	96%	96%	95%	91%	93%	92%	96%	96%	97%	92%	90%		
UC-4	Total Emergency Admissions IP Activity Monitoring	165	151	176	200	177	203	175	176	167	151	159	157	188	1980	2080
UC-5	Emergency Admissions IP Activity Monitoring (AB	148	178	180	176	204	192	182	188	203	183	163	174	178	1776	2201

Ref	**ADULT CARE**															
AC-1	Total Number of Adult Referrals	716	517	549	585	628	618	576	598	686	573	583	592	758	8592	7263
AC-2	Total Number of UAA Assessments	224	275	288	344	216	257	252	235	264	174	196	209	261	2688	2971
AC-3	Total Adult Protection Referrals	24	24	24	21	24	28	32	27	42	28	19	36	32	288	337
AC-4	Total New People in Receipt of Homecare	36	40	39	32	46	28	29	29	24	28	38	35	52	432	420
AC-5	Total New Care Home Placements	16	22	22	20	14	24	17	27	18	21	9	13	37	192	244
AC-6	Total No of Delayed Discharges Awaiting Care Home	5	4	4	5	7	8	13	12	10	4	10	13	16		
AC-7	Total No of Delayed Discharges Awaiting Homecare	5	8	7	12	13	13	9	15	14	18	13	11	18		
Ref	**COMMUNITY HEALTH**															
CH-1	Total Mental Health – New Episodes	80	52	60	59	64	76	69	38	41	50	41	60	48	960	658
CH-2	Total Mental Health – Patient Contact Notes	584	885	828	881	769	794	747	735	851	757	689	685	794	7008	9415
CH-3	Total DN – New Episodes	92	130	136	123	150	124	112	101	112	93	105	91	82	1104	1359
CH-4	Total DN – Patient Contact Notes	4032	4490	4428	4634	4883	5046	4715	4758	4628	4677	4429	4054	4411	48384	55153
CH-5	Total AHP - New Episodes	276	350	352	410	373	388	356	375	441	337	311	374	384	3312	4451
CH-6	Total AHP - Patient Contact Notes	3096	2895	3083	3354	3289	3247	3514	3365	3820	3309	3350	2940	3763	37152	39929
Ref	**CHILDREN & FAMILIES SOCIAL CARE**															
CF-1	Total Number of Child Request for Assistance	196	248	238	280	173	275	347	257	306	326	287	176	248	2352	3161
CF-2	Total Number of New Universal Child Assessments	88	85	109	101	59	125	88	96	108	60	81	90	73	1056	1075
CF-3	Total Number of Children on CP Register	38	31	28	29	32	31	32	37	36	31	33	25	27		

(Please note that not all MH community and AHP activity is captured due to data lag and some services are not yet on automated systems)

Remobilisation Performance Assessment:

The information presented shows good progress with regards to the scale of mobilisation of our services in the HSCP with increasing activity across our health and care system. Some points to note:

- Cumulative total outpatient activity across new and return notes a (59%) increase against target
- Total urgent suspicion of cancer referrals received notes a (31%) increase in activity for March (55) against the previous month (42)
- Lorn & Islands Hospital total percentage of attendances at A&E seen within 4 hrs notes a (5%) reduction for March against target (95%)
- Total number of adult referrals note a (22%)increase for March against previous month
- Total number of assessments completed note a (20%) increase for March against previous month
- Cumulative total Endoscopy and Radiology activity notes a (11%) increase against target

- Total mental health patient contacts notes an increase a (16%) increase in March (794) against previous month (685)
- Total number of child requests for assistance notes a (41%) increase for March (248) against the previous month (176)
- Total new child universal assessments notes a (19%) reduction in March (73) against the previous month (90)
- The number of delayed discharges has increased for those awaiting both Homecare (18) and Care Homes (16)

4.2 Waiting Times Performance

The tables below identifies the New Outpatient Waiting List and times by main speciality as at the 23rd March 2022, Comparator data for February in red is used identify changes across specialities and waits.

A&B Group Totals	Extracted 23rd March 2022				
	New Outpatient Waiting List				
	Length of Wait (weeks)		Total on List	Long Waits (over26)	% Breaches of each Group OPWL
Main Specialty	Over 12	Under 12			
Consultant Outpatient	305(275)	938 (905)	1243 (1180)	53 (49)	24.5% (23.3%)
AHP	226(220)	370 (347)	596 (567)	109 (98)	37.9% (38.8%)
Mental Health	486 (470)	247 (194)	733 (664)	324 (316)	66.3% (70.8%)
Nurse Led Clinics	23 (23)	163 (148)	186 (171)	3 (1)	12.4% (13.5%)
Other/Non MMI	380 (356)	702 (577)	1082 (933)	154 (142)	35.1% (38.2%)
TOTAL OPWL **Previous Month**	**1420** **(1344)**	**2420** **(2171)**	**3840** **(3515)**	**643** **(606)**	**37%** **(38.2%)**

	Length of Wait (weeks)		Total on List	Long Waits (over26)	% Breaches of each Group OPWL
Main Specialty	Over 6	Under 6			
Scopes * **Previous Month**	**196** **(149)**	**130** **(108)**	**326** **(257)**	**32** **(23)**	**60.1%** **(58.0%)**

	Length of Wait (weeks)		Total on List	Long Waits (over26)	% Breaches of each Group OPWL
Main Specialty	Over 4	Under 4			
MSK ** **Previous Month**	**1068** **(1171)**	**443** **(467)**	**1511** **(1638)**	**252** **(280)**	**70.7%** **(71.5%)**

Waiting Times Performance Assessment:

- Total new outpatient waiting list notes a reduction of percentage breaches of (1.2%) for February against the previous month
- Scopes note a 23% increase in those on the waiting list for February (326) against the previous month (257)
- Musculoskeletal physiotherapy waits note a reduction across all their waits for February, including a (8%) reduction of total number of waits on the list and a (1.5%) reduction in total percentage breaches.

- Total waits greater than 12 weeks has increased by (6%) against the previous month with an associated increase in those waiting less than 12 weeks of (11%)
- Overall percentage breaches note that Nurse lead clinics note a further reduction (1.1%) for February against the previous month, this also include reduction in Mental Health (4.5%), Allied Health Professionals (0.9%) and Other (3.1%)

4.3 Virtual Outpatient Performance

The table below illustrates monthly cumulative virtual new and return consultant outpatient performance for Lorn & Islands Hospital and Community Hospitals in Argyll and Bute.

Cumulative Virtual Consultant Outpatient Activity				
Reporting Period	**Lorn & Islands Hospital New**	**Lorn & Islands Hospital Return**	**Community Hospitals New**	**Community Hospitals Return**
January	640	1800	194	827
March	769	2030	230	987
Variance	+129	+230	+36	+160

(Data Source- NHS Highland Remobilisation Plan Data- Cumulative Virtual New and Return Outpatient- March 2022)

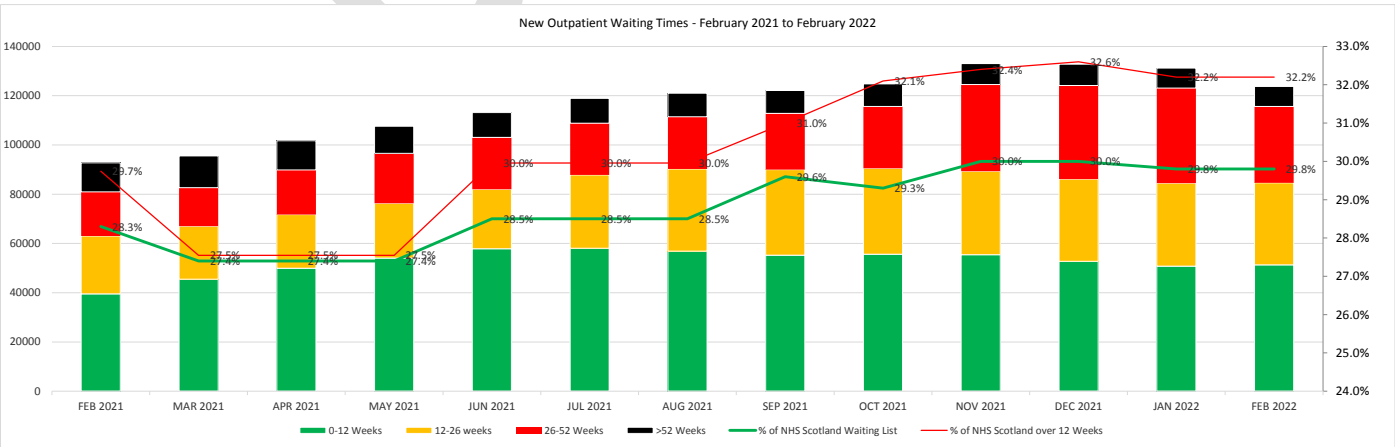
Performance Assessment:

- Cumulative Virtual Consultant Outpatient activity for Lorn & Islands Hospital notes a (15%) increase in virtual appointments for March against the previous month
- Cumulative Virtual Consultant Outpatient activity for Community Hospital notes a (19%) increase in virtual appointments for March against the previous month

4.4 Greater Glasgow & Clyde Outpatient Remobilisation Performance

This report notes the current Greater Glasgow and Clyde Performance with regards to targets identified with their Remobilisation Plan (RMP3) for April 2022.

NHS GG&C Waiting Times (February 2021- February 2022)



(Data Source - NHS GREATER GLASGOW & CLYDE BOARD MEETING/ Performance Assurance information- April 2022)

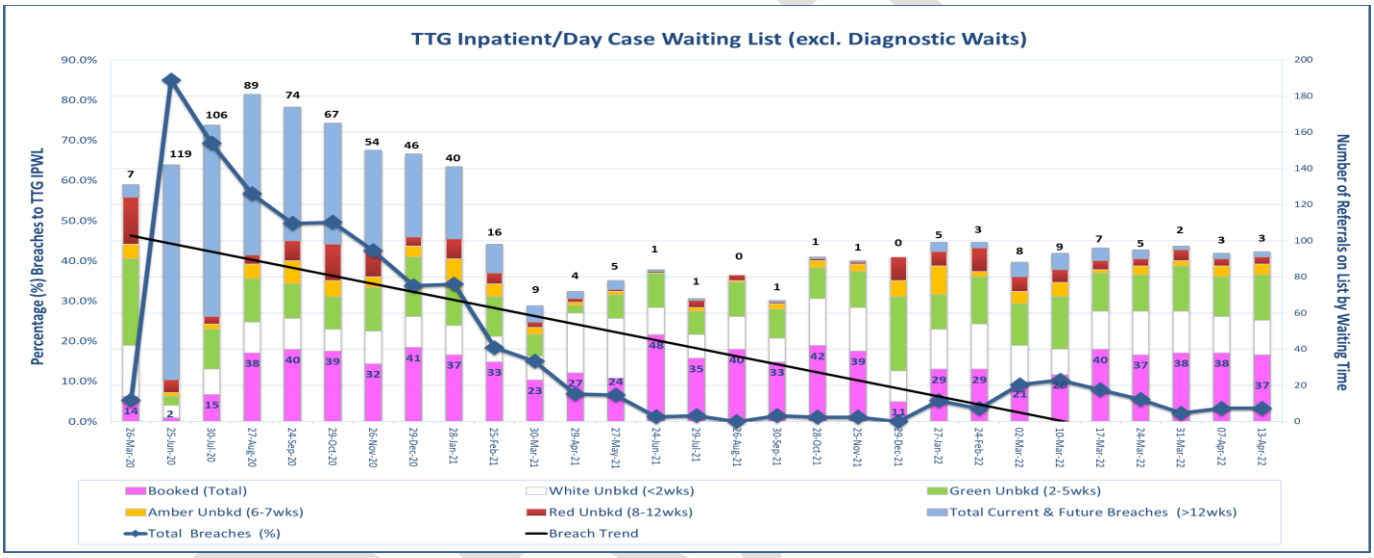
Performance Assessment:

- At the end of February 2022, 123,757 patients were on the new outpatient waiting list, of this total 72,469 were waiting >12 weeks against the RMP4 target of 70,000. The number of patients waiting >12 weeks is 3.5% above the RMP4 target.
- 29.8% of the total patients waiting across NHS Scotland for a first new outpatient appointment were NHSGGC patients at the end of February 2022.

4.5 Treatment Time Guarantee (TTG) - Inpatient/Day Case Waiting List

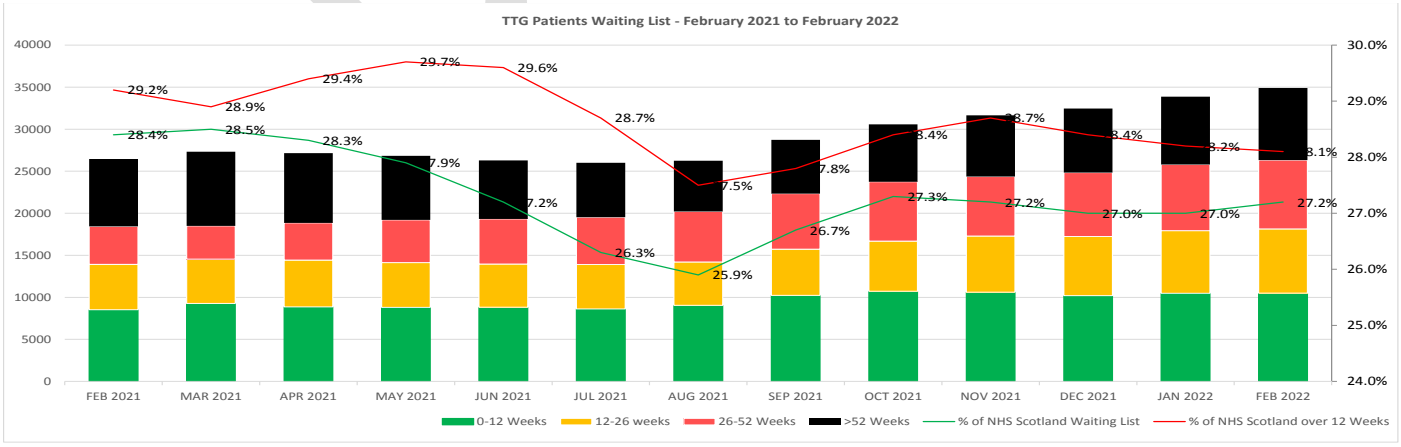
Argyll & Bute Inpatient/Day Case Activity

The graph below identifies current performance with regards to Inpatient /Day Case -12 week breaches and current overall performance as at 17th February 2022 in Argyll and Bute at LIH, Oban



Greater Glasgow & Clyde- Treatment Times Guarantee (TTG) - Waiting Times

The graph below notes current performance with regards to TTG Inpatient and Day Case Activity against trajectory from Feb 2021 to Feb 2022



(Data Source - NHS GREATER GLASGOW & CLYDE BOARD MEETING/ Performance Assurance information- April 2022)

Performance Assessment:

Argyll & Bute

- Total breaches > 12 weeks on the TTG waiting list note 3.3% as at 13th April with 40.2 % noted as booked.
- NHS Scotland Board Level Performance for TTG is identified in **Appendix 1**

Greater Glasgow & Clyde

- At the end of February 2022, there were 34,899 patients on the overall waiting list. Currently 24,401 patients waiting >12 weeks against a target of 19,154. Above target by 27%.
- Currently 28.1% of the >12 weeks national waiting list at the end of February 2022.

4.6 Future Performance Reporting Arrangements

The IJB is asked to note following future performance reporting arrangements:

- The HSCP's Integrated Performance Management Framework (IPMF) will be rolled out across the HSCP with a collaborative and consultative approach adopted across the Senior Leadership Team over 2022/23, in line with timescales agreed by SLT.

- IPMF governance will be applied through the Clinical and Care Governance Committee.

- Current IJB Performance Report will remain extant until the IPMF, its associated Key Performance Indicators (KPIs), and the governance & scrutiny arrangements are fully embedded within SLT.

- As per previous 2 years, using the mechanisms as laid out in the Coronavirus Scotland Act (2020), Schedule 6, Part 3, the Scottish Government have confirmed the 2021/22 Annual Performance Report (APR) will be due for publication by November 2022.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

The monitoring and reporting of performance with regards to Argyll & Bute HSCP, Greater Glasgow & Clyde and NHS Highland ensures the HSCP is able to deliver against key strategic priorities.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact

NHS Highland remobilisation plan has received additional funding from the Scottish Government and this includes direct funding to the HSCP of £590,840.

6.2 Staff Governance

There has been a variety of staff governance requirements throughout this pandemic which have been identified and continue to be progressed and developed include health and safety, wellbeing and new working practices within national Covid19 restrictions as part of our mobilisation plans.

6.3 Clinical Governance

Clinical Governance and patient safety remains at the core of prioritised service delivery in response to the pandemic and subsequent remobilisation.

7. PROFESSIONAL ADVISORY

Data used within this report is a snapshot of a month and data period, where possible data trends are identified to give wider strategic context.

8. EQUALITY & DIVERSITY IMPLICATIONS

EQIA not required

9. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

Data use and sharing within this report is covered within the A&B & NHS Highland Data Sharing Agreement

10. RISK ASSESSMENT

Risks and mitigations associated with data sources and reporting are managed and identified within the monthly Performance & Improvement Team- Work Plan

11. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

Full access to this report for public is via A&B Council and NHS Highland websites

12. CONCLUSIONS

The Integration Joint Board is asked to consider the work to date with regards to improved performance against Remobilisation and Waiting Times targets. Consideration should also be given to the potential impact of the new Omicron variant with regards to future performance reporting and prioritisation of service delivery.

13. DIRECTIONS

Directions required to Council, NHS Board or both.	**Directions to:**	tick
	No Directions required	x
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

REPORT AUTHOR AND CONTACT

Author Name: Stephen Whiston
Email: stephen.whiston@nhs.scot

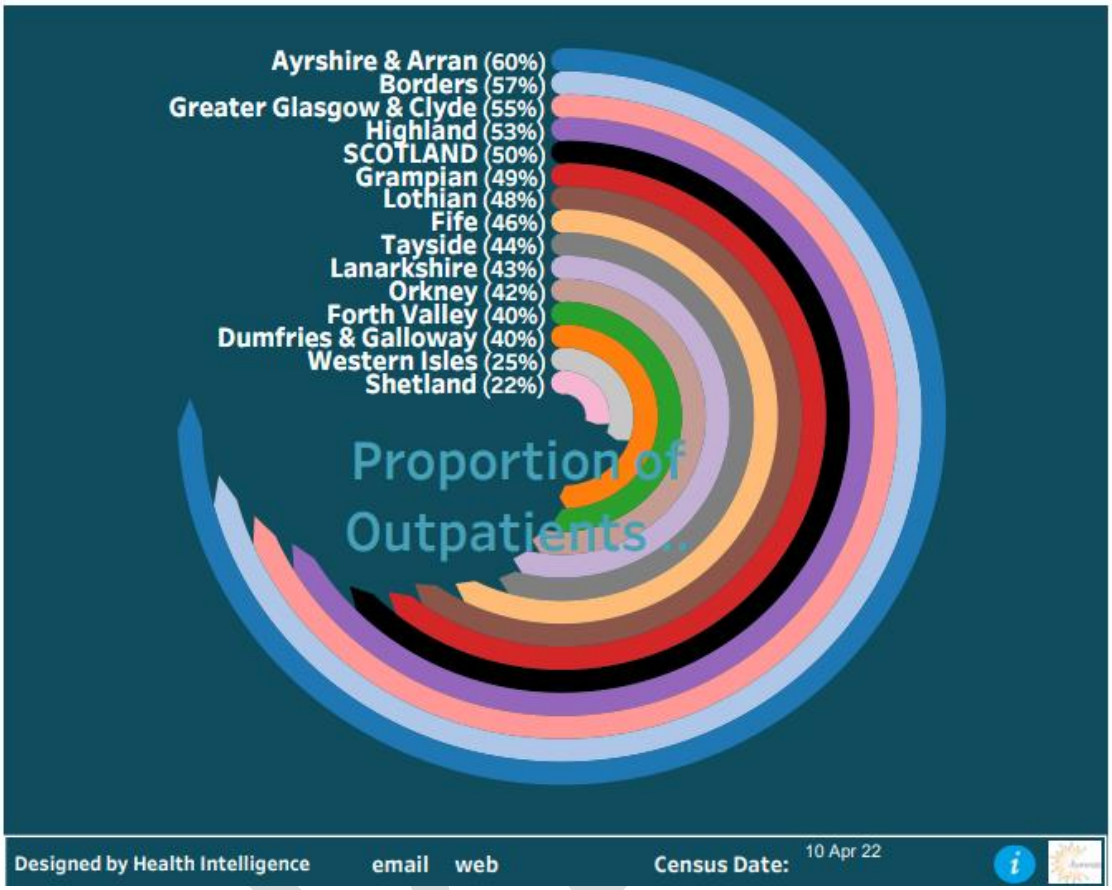
Appendix 1- Board Level KPI's – 10th April 2022

Board Level KPIs Summary

10 April 2022

	OPWL - waiting over 12 weeks	Core 4 hour ED Performance (..	Patients Spending over 8 hours in core ED ..	Patients Spending over 12 hours in co..	Core ED Attendances (week)	Delayed Discharges (total)	TTG - patients waiting over 12 weeks	TTG - patients waiting over 26 weeks	OPWL - waiting over 26 weeks
SCOTLAND	213,293	66.4%	2,483	999	23,905	0	88,960	62,489	119,338
Ayrshire & Arran	24,769	68.0%	282	160	1,749	0	5,970	4,311	16,139
Borders	5,186	59.4%	130	90	557	0	1,547	1,170	3,468
Dumfries & Gallo..	4,298	81.7%	18	2	903	0	1,341	628	1,529
Fife	10,069	60.7%	156	41	1,215	0	1,972	890	4,771
Forth Valley	6,588	53.1%	84	14	1,106	0	1,675	793	2,698
Grampian	18,991	63.2%	169	36	1,642	0	11,840	8,617	10,660
Greater Glasgow ..	70,188	64.3%	558	133	5,836	0	25,754	18,659	40,753
Highland	9,747	78.1%	50	10	1,103	0	4,959	3,688	5,562
Lanarkshire	17,268	58.8%	427	130	3,545	0	9,100	6,541	8,769
Lothian	35,413	64.9%	598	383	4,395	0	16,491	11,493	19,774
Orkney	373	95.5%	0	0	89	0	112	59	175
Shetland	216	96.4%	0	0	139	0	97	58	87
Tayside	9,900	90.3%	11	0	1,529	0	7,262	5,212	4,829
Western Isles	269	95.9%	0	0	97	0	264	111	117
Grampian as % of Scotland		6.81%	3.60%	6.87%		13.40%	13.85%	8.90%	8.93%
Highland as % of Scotland		2.01%	1.00%	4.61%		5.61%	5.93%	4.57%	4.66%
Tayside as % of Scotland		0.44%	0.00%	6.40%		8.22%	8.38%	4.64%	4.05%

Appendix 2- Proportion of Outpatients Waiting Over 12 Weeks by Health Board (10/04/2022)



A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Integrated Joint Board

Date of Meeting: 25th May 2022

Title of Report: Joint Strategic Plan (2022 – 2025)

Presented by: Kristin Gillies Senior Service Planning Manager

The IJB is asked to:

- **Approve** the HSCP Joint Strategic Plan (2022-2025) attached for implementation.

1. EXECUTIVE SUMMARY

1.1 Argyll and Bute Integration Joint Board is asked to approve the first Joint Strategic Plan (JSP) to cover the period April 2022 to March 2025.

1.2 The Public Bodies (Joint Working) (Scotland) Act 2014 places a duty on Integration Joint Boards to develop a JSP for integrated functions and budgets that they control, reviewing the plan at least every three years.

1.3 The JSP is a high level strategy which sets out our vision, strategic objectives and priorities. The JSP is closely linked with the Joint Strategic Commissioning Strategy (JSCS) which was approved in March 2022.

1.4 The JSP was developed over the last year by the Strategic Planning Group (SPG) supported by the Market Facilitation and Strategic Commissioning Steering Group and has included public, stakeholder and staff engagement.

2. DETAIL OF THE REPORT

2.1 The HSCP is responsible for the planning and delivery of high quality health and social care services to and in partnership with the communities of Argyll and Bute to achieve the National Health and Wellbeing Outcomes (NHWBO) and the Children and Young People Outcomes.

2.2 The methodology used for the JSP was agreed by the SPG on 3rd June 2021. This involved the development of a project plan outlining how each of the strategic leads would complete a template detailing how their actions progressed over the time period of the last JSP, what challenges they faced including the impact of Covid-19, their objectives and priorities over the next three years.

2.3 The vision, strategic objectives, priorities and commissioning intentions were developed from discussion with a number of groups and were also informed by national and local policy drivers. These were consulted on over the period and were adapted following feedback. An additional strategic objectives was added to ensure that children and young people services were highlighted. The assessment and forecasting of future and current needs and the delivery of services will take account of the HSCP priorities which embrace prevention, self-management, choice and community based services.

2.4 The Joint Strategic Needs Assessment was updated over the year to ensure that it was utilising the most recent published data and reflected the impact of the Covid-19 epidemic.

2.5 An engagement specification and engagement plan was agreed by the SPG and this was undertaken from September to December 2021. This included a staff and public survey; an online webinar; staff, third and independent sector and SPG consultation events as well as a blueprint workshop.

2.2 The JSP has been produced to outline:

- The high level vision, strategic objectives and priorities that all services will work towards and how these link to the NHWBO
- How we will measure our performance
- How the HSCP will effectively use allocated resources, and set budgets and a financial strategy to meet what is outlined within the strategic plan
- What the current and future needs are as set out within a Joint Strategic Needs Assessment (JSNA)
- How we engaged with the public, staff and other stakeholders and the results of the engagement
- How we plan to remobilise services over the next three years
- How each operational area is planning to meet their three year priorities
- How housing is intrinsically linked with the planning and delivery of services
- How we will measure the performance of each operational area

2.3 The JSP will be monitored on a quarterly basis by the Strategic Planning Group which will:

- Oversee the delivery of the JSP on behalf of the IJB
- Review the JSP annually and monitor progress via production of the Annual Performance Report
- Provide a view on operational strategies and ensure they are in line with the high level strategic objectives and priorities
- Review detailed business cases and change plans on behalf of the IJB
- Communicate to the IJB that there's been appropriate discussion and engagement
- Provide a forum for discussion of emerging themes and initiative

- Take note of and act upon national policy, guidance, objectives and feedback from Scottish Government

2.4 The delivery and review steps will be undertaken by each strategic group once the strategy is enacted. This will cyclically feed into further refining and developing our Joint Strategic Plan and Joint Strategic Commissioning Strategy over the three year period.

3. RELEVANT DATA AND INDICATORS

3.1 There is a significant volume of data and intelligence within the Commissioning Strategy including:

- Financial Data: Expenditure, budgets and analysis – source HSCP Social Work Finance Team and Planning Analysts
- Health needs assessment including population and demography Data - Source: HSCP Planning Analysts and Public Health
- Service Data- Source: HSCP Planning Analysts and Commissioning /Procurement team
- Procurement Data – Contracts and Service Level Agreements Data Source: Argyll and Bute Council Commissioning and procurement team.
- User experience and provider feedback – Source: Third and Independent sector, provider feedback and performance returns

4. CONTRIBUTION TO STRATEGIC PRIORITIES

4.1 The Joint Strategic Plan sets out the strategic priorities.

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact

The contents of this report will have a financial impact to the IJB. The IJB approved budget for 2022/23 financial year however, takes this into account. The financial planning process for 2023/24 onwards will need to align with the outcome of enacting the JSCP as detailed in the plan and will be submitted to the IJB for approval each year.

5.2 Staff Governance

There may be an impact on some staff due to enactment of the JSP. If so the change processes detailed in our staff governance arrangements will be applied working with our trade union partners.

5.3 Clinical Governance

There is no impact on existing clinical and care governance arrangements

6. EQUALITY & DIVERSITY IMPLICATIONS

An Equality Impact Assessment is attached at Appendix Three

7. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

The engagement specification and plan is attached at Appendix Four.

8. RECCOMENDATION

The Integration Joint Board is asked to approve the HSCP Joint Strategic Plan for implementation.

9. DIRECTIONS

Directions required to Council, NHS Board or both.	**Directions to:**	tick
	No Directions required	X
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

10. REPORT AUTHOR AND CONTACT

Author Name Kristin Gillies/Alison Ryan
Email Kristin.Gillies@nhs.scot

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Joint Strategic Plan 2022-2025

PEOPLE IN ARGYLL AND BUTE WILL LIVE LONGER, HEALTHIER INDEPENDENT LIVES

This document can be made available in a range of formats and languages,
For contact details please see the last page of this document.

CONTENTS

APPENDICES

PRIORITIES AND COMMISSIONING INTENTIONS

CHOICE AND CONTROL & INNOVATION

- We will ensure from the point of assessment, people are given informed choices and options to meet their specific personal outcomes and wishes
- We will work with carers as partners in the care of their loved ones
- We will ensure all services deliver a more personalised type of support
- We will aim to have services based within communities to prevent people moving away and bringing people back into Argyll and Bute
- We want all services to comply with the National Health and Social Care Standards for Health and Social Care: My Support, My Life
- We will work with communities, providers and advocacy bodies to set a vision for their community and co-produce community based services to support people with options and choice
- We will ensure that every decision will be made in consultation and engagement with the people of Argyll and Bute, and will have a positive effect for those with protected characteristics
- We will communicate in a clear, open and transparent way

PREVENTION, EARLY INTERVENTION AND ENABLEMENT

- We will ensure that people can live safely in their own home and limit the time spent in hospital
- We will refocus on preventative services, including a shift to digital technology using Telecare and Telehealth to reduce hospital visits and admissions
- We will keep adults, children and young people safe from harm
- We will ensure that everyone who is part of providing support is **trauma informed**

PEOPLE IN ARGYLL AND BUTE WILL LIVE LONGER, HEALTHIER INDEPENDENT LIVES

PRIORITIES

LIVING WELL AND ACTIVE CITIZENSHIP

- We want all commissioned services to work in partnership with HSCP staff, people who use the service, their carers and families to support personal outcomes and empower service users to successfully engage and continue to contribute to the life of their community
- We will develop a preventative approach and promote independence and self-management within our communities. All services will enable, not disable, including supporting self-management; physical activity; enablement

COMMUNITY CO-PRODUCTION

- We will work with communities, providers and advocacy bodies to set a vision for their community and co-produce community based services to support people with options and choice
- Where possible we will commission services locally and build capacity providers and third sector partners in line with the five pillars of Community Wealth Building
- We will ensure that we have an inequalities sensitive practice, targeting resources where they have most impact

NATIONAL HEALTH AND WELLBEING OUTCOMES & STRATEGIC OBJECTIVES

National Health and Wellbeing Outcomes	Strategic Objectives
People are able to look after and improve their own health and wellbeing and live in good health for longer	**Reduce the number of avoidable emergency hospital admissions & minimise the time that people are delayed in hospital**
People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in the community	**Support people to live fulfilling lives in their own homes for as long as possible**
People who use health and social care services have positive experiences of those services, and have their dignity respected	**Institute a continuous quality improvement management process across the functions delegated to the partnership**
Health and social care services are centred on helping maintain or improve the quality of life of people who use those services	**#KEEPTHEPROMISE**
Health and social care services contribute to reducing health inequalities	**Promote health and wellbeing across our communities and age groups**
People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing	**Support unpaid carers, to reduce the impact of their caring role on their own health and wellbeing**
People using health and social care services are safe from harm	**Promote health and wellbeing across our communities and age groups**
People who work in health and social care services feel engaged with the work they do and are supported to continually improve the information, support, care and treatment they provide	**Support staff to continuously improve the information, support and care they deliver**
Resources are used effectively and efficiently in the provision of health and social care	**Efficiently and effectively manage all resources to deliver best value**

FOREWORD

Welcome to the Argyll and Bute Health and Social Care Partnership's (HSCP) third Strategic Plan for the years 2022-25.

Creating and developing a Strategic Plan during the Covid 19 Pandemic has had its challenges. This has been magnified by the uncertainty ahead with the significant legislative changes on the horizon mainly the National Care Service and the Independent Review of Adult Social Care. That aside, the HSCP feel now is the time to set out our strategic direction for the next 3 years, to be ambitious, values based and aspirational yet realistic around what we can achieve and to support the remobilisation of services following the impact the pandemic has had on our services, workforce and society as a whole.

As a rural Health and Social Care Partnership, our geography and demographic can at times be perceived as challenging but in Argyll and Bute we have tried to use this as an opportunity to push our boundaries around the use of digital technology, when appropriate, and different ways of working. Covid 19 has forced us to enact changes and seize opportunities when they have come our way, and we now have the opportunity to share what we have learnt, to learn from others and to develop the way we deliver services, preparing us for the future.

This is just the start of the process. The Joint Strategic Plan pulls together for each strategic area, the objectives and priorities for the coming three years and how these will be measured and monitored. All of the priorities and actions will be linked to the objectives, priorities, and the intention is to ensure that every staff member and every service works towards our ultimate vision.
Our focus on community wellbeing and the development of local services will also contribute to the economic stability of the area.

Over the last 3 years, we have strengthened the governance of our Integration Joint board to ensure operational accountability. We have worked hard to try and improve our approach to integration by building on the success of multi-disciplinary teams and practices and this next strategic plan will continue to do this as we assess the need for transformation of services. Despite the pressures and challenges of the pandemic, we have worked hard to engage with our partners, stakeholders, and specifically our residents in Argyll and Bute to develop this plan, with the aim of ensuring we support people in Argyll and Bute to lead long, healthy, independent lives.

Sarah Compton-Bishop

Chair of Argyll & Bute Integration Joint Board

INTRODUCTION

I would like to introduce myself as the Chief Officer for Argyll and Bute Health and Social Care Partnership.

Firstly, we need to acknowledge that we have been, and still are, in unprecedented times. We all, as individuals, families, communities and services had to respond quickly to the impact of Covid-19. Unfortunately, we are still in the midst of this and have a requirement to continue to maintain existing services. However, it is important that we do not lose the lessons of how we all pulled together in a crisis, how partnerships were forged, how communities pulled together, how bureaucracy was removed as a barrier. It is also important to plan. To plan for now and to plan ahead for the future.

Planning is about taking time to understand the health and social care needs of our local communities, islands, families and individuals to allow us to work with our partners in the NHS and Local Authority and throughout the public, third and independent sectors to think about what services we want in place in response.

There are some services which are available to everyone which can be either preventative, like vaccination and screening programmes or available when we are feeling unwell like GPs and Pharmacists. However, there are times when each of us can be more vulnerable and need health and social care specialist or support services. This could be due to age, a medical condition, disability, trauma or life circumstances.

Fiona Davies

Chief Officer Argyll & Bute HSCP

We have set out the vision People in A&B will live longer healthier independent lives and our high level priorities of;

- Prevention, early intervention and enablement,
- Choice and control and Innovation,
- Living well and active citizenship,
- Community co-production”

Our Strategic Plan hopefully maps for you a realistic picture of a complicated landscape, and creates the conditions to share resources, maximise the potential of the totality of our assets and strive ahead as we come out of the Covid 19 Pandemic and look towards living with not only Covid but the consequences we have seen from it well into the future. In particular we are looking to develop a Islands Strategy over 2022/23.

The COVID-19 pandemic has reminded us, once again, that our workforce are our greatest resource and this plan will also guide us as our plans to promote the wellbeing of staff through our workforce and that of our partners. We are currently developing a National Health and Social Care Workforce Strategy, which will be incorporated as part of this plan later in the year.

I look forward to working with you all in Argyll and Bute to achieve the best Health and Social Care service we can and to lead our organisation through these uncertain and changing times ahead.

If you would like to share feedback on the Joint Strategic plan and/or Specific Individual area. Please share your comments and feedback via our online survey click here. A paper Survey can be requested please contact nhsh.strategicplanning@nhs.scot

BACKGROUND AND CONTEXT

Argyll and Bute HSCP brings together a wide range of health and social care services across Argyll and Bute. Services are provided by the HSCP or are purchased from the Independent and Third Sector.

SERVICES FOR ALL STAGES OF LIFE

In Argyll and Bute, the HSCP delivers and purchases a broad range of services covering all aspects of health and social care. Included in the remit of the HSCP are:

- NHS services ; Community hospitals; Acute Care; Primary Care (including GPs); Allied Health Professionals, Community Health Services, Maternity Services
- Public Health services including the Prevention agenda
- Adult social care services including services for older adults; people with learning disabilities; and people with mental health problems
- Children & Families social care services
- Alcohol and Drug Services
- Gender Based Violence
- Child and Adult Protection
- Criminal and Community Justice Services

In bringing together all these services within one partnership and one strategy we aim for services to work closer together so that people receive the right level of care at the right time from our workforce of professional staff and can move through services easily.

We need to ensure that we plan services strategically from the population and local data, evidence and what people and our workforce tell us. We need a range of services from prevention programmes to critical care.

All services are strategically driven by local and national priorities and full service details are provided within the

5.6a Argyll and Bute Integration Scheme

THE INTEGRATION JOINT BOARD

The Public Bodies (Joint Working) (Scotland) Act, establishing integrated health and social care partnerships on a legal footing, came into effect on 2 April 2014 and this is the third Strategic Plan of the Integration Joint Board (IJB).

The HSCP is governed by the IJB – a separate legal entity in its own right - which is responsible for planning and overseeing the delivery of community health, social work and social care services. The IJB is responsible for allocating the integrated revenue budget for health and social care in accordance with the objectives set out in its Strategic Plan.

The IJB includes members from NHS Highland, Argyll & Bute Council, representatives of the Third Sector, Independent Sector, staff representatives and others representing the interests of patients, service users and carers.

A THREE YEAR VISION

We have decided to develop a three year strategy for our services as there are some legislative changes coming over the next three years which would make it difficult to plan any longer than this. However, our objectives, priorities and commissioning intentions are unlikely to change as they have been set in line with the Review of Adult Social Care. We will continue to work to meet the Health and Wellbeing Outcomes and national and local outcomes set within individual strategies.

Each service is currently developing their own Operational Plan and Commissioning Plan and as such our HSCP Strategic Plan will be an iterative document in response to these plans, and in response to the national policy developments and the recovery plans following Covid-19. The diagram in the next page shows how all of the strategies will link into the Joint Strategic Plan and the **Joint Strategic Commissioning Strategy**

The monitoring of the plan will be on a quarterly basis when the performance measurement targets are presented to the IJB and the Strategic Planning Group (SPG).

Working with third and community sector partners

The HSCP is making a clear statement about working with a wide range of partners from the Third and Independent sectors to improve the health and wellbeing of our communities. Supporting people to take control and responsibility for their own health and wellbeing means co-producing a range of services that are designed and led by local communities. This will not only support the prevention agenda but in developing the capacity of organisations to deliver community led services it will also support community wealth building and resilience.

We will also link into the localities alongside our Locality Planning Groups and Community Planning Partnership to deliver support and services in keeping with local need and have plans to develop a specific Islands strategy.

4 PRIORITY AREAS

8 STRATEGIC OBJECTIVES

NINE HEALTH & WELLBEING OBJECTIVES

JOINT STRATEGIC PLAN

ENGAGEMENT

GOVERNANCE

JOINT STRATEGIC COMMISIONING STRATEGY

LOCALITY PLANNING GROUPS

STRATEGIC PLANNING GROUP

TRANSFORMATION BOARD

CLIENT GROUP COMMISSIONING PLANS

LIVING WELL NETWORKS

STRATEGIC HOUSING

STRATEGIES

MENTAL HEALTH	GENDER-BASED VIOLENCE	LEARNING DISABILITY
OLDER PEOPLE	CARERS	SUICIDE PREVENTION
CHILDREN & YOUNG PEOPLE	ALCOHOL & DRUG PARTNERSHIP	PHYSICAL ACTIVITY
PREVENTION / LIVING WELL	CHILD POVERTY ACTION PLAN	DIGITAL

JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) AND POPULATION PROFILES

Understanding Argyll and Bute

As set out in the 2019/20 to 2021/22 Joint Strategic plan, Argyll and Bute HSCP is divided into four locality planning areas. Within three localities, there are further divisions into 'local areas' which consist of groupings of natural geographical communities and/or service provision. Planning may sometimes be necessary for smaller areas within a locality e.g. for one island. Localities and local areas are as follows:

HSCP Locality	Local Area	Settlement (of 500 people or more) [1][1]	Hospital
Bute and Cowal (B&C)	Bute	Rothesay, Port Bannatyne	Victoria Hospital
	Cowal	Dunoon, Hunter's Quay, Innellen, Tighnabruich	Cowal Community Hospital
Helensburgh and Lomond (H&L)		Helensburgh, Cardross, Gareochhead, Rosneath, Kilcreggen	Victoria Integrated Care Centre, Helensburgh
Mid Argyll, Kintyre and Islay (MAKI)	Mid Argyll	Lochgilpead, Tarbert, Ardrishaig	Mid Argyll Community Hospital and Integrated Care Centre
	Kintyre	Campbeltown	Campbeltown Hospital
	Islay and Jura	Bowmore, Port Ellen	Islay Hospital
Oban, Lorn, and the isles (OLI)	Oban and Lorn	Oban, Dunbeg	Lorn & Island Hospital
	Mull, Iona, Coll, Tiree and Colonsay	Tobermory	Mull & Iona Community Hospital

Our Joint Strategic Needs Assessment (JSNA) for adults was conducted in 2019 [2] with a data review for children and families completed in 2020 [3]. In addition, the 2019 Director of Public Health's Annual Report highlighted population and health trends in NHS Highland [4]. To update the information gathered, profiles have been provided by Public Health Scotland Local Intelligence Support Team (PHS LIST) [6]. The disruptions caused by the COVID-19 pandemic mean that some 2020 and 2021 data is difficult to interpret; reviews conducted prior to COVID-19 provide the best available information in some areas. A specific review into the impact of COVID-19 was conducted in December 2020 [6]. The summary presented here draws on all these resources and aims to highlight the health and wellbeing of the population of Argyll and Bute as well as the challenges for Argyll and Bute HSCP in planning and delivering health and social care services.

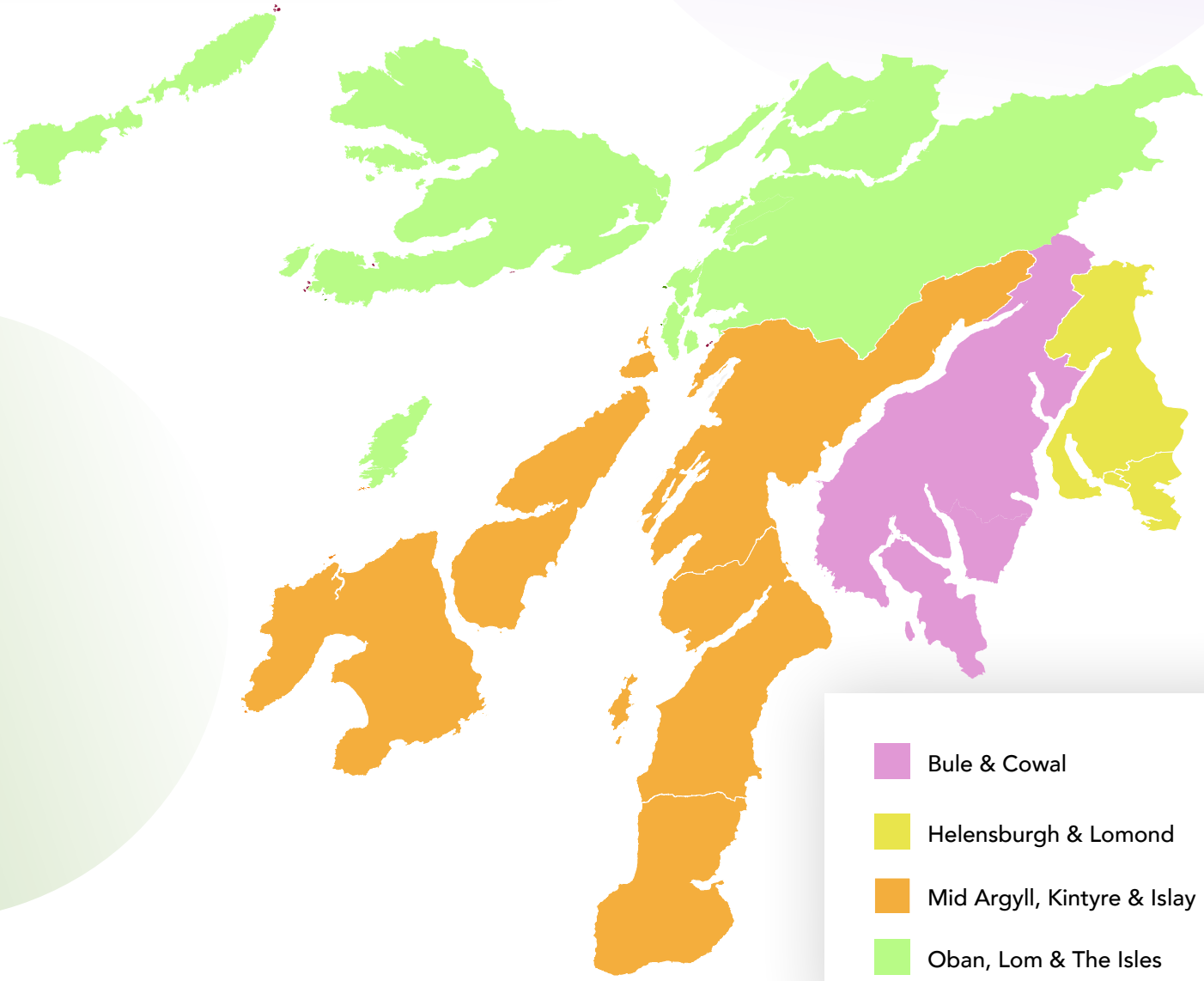
Please see Appendix 2 for references and Appendices 3-12 for accompanying documents.

1 NRS, 2016 Settlements and Localities I National Records of Scotland (nrscotland.gov.uk)

Figure 1

Argyll and Bute HSCP
Locality Planning Group areas 2022/2025

Areas are represented based on a best fit of 2011 datazone areas with an adjustment to place colonsay in OLI



Locality Planning Groups (LPGs) are required to develop, engage, communicate and enact the implementation of the 3 year Strategic Plan, at locality level, by developing their own annual Locality implementation plan.

Following an Option Appraisal Workshop in October 2018 attended by Locality planning group members, participants' agreed that the model of nine locality planning groups was not working and required urgent revision to achieve more efficient and effective shared planning across Argyll & Bute. A 'Four Locality Planning Group Model' overwhelmingly emerged as the preferred model for future locality planning arrangements in Argyll and Bute.

Unfortunately, the Locality Planning Groups across Argyll and Bute were put on hold due to the operational focus required by HSCP during the pandemic. The HSCP is committed to re-establishing the groups within the first year of this plan.

DEMOGRAPHICS

The 2020 mid-year population estimate for Argyll and Bute is **85,430, a 3.6% decrease since 2010**, with the number of deaths registered higher than the number of births each year since the early 1990s [2].

In particular, the **population of working age has decreased** and is projected to continue to do so. Alongside this, the population of those under 16 has decreased and this is also projected to continue [3].

In contrast, the population of those aged 75 and over has increased each year since 2002 with **11.7% of the population aged 75+** compared to 8.6% in Scotland as a whole [2]. The number of people aged 75+ and 85+ is projected to continue to increase over the next 10 years [3].

Bute and Cowal have the highest proportion of people aged over 65 [4].

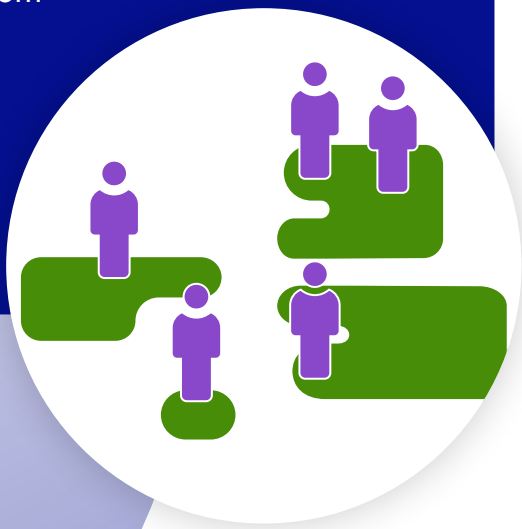
85,430 PEOPLE 3.6% SINCE 2010

WORKING AGE POPULATION

THE OLDEST IN THE POPULATION

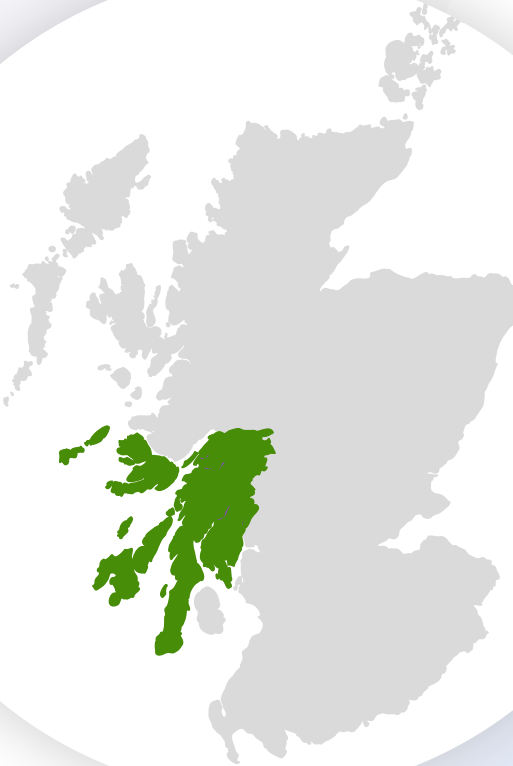
CHALLENGES

- Increased demand for health and social care services from continued increases in the numbers of older people.
- Increased need for end of life care [9, p. 72].
- Maintain workforce as the population of working age decreases.



LIFE CIRCUMSTANCES

A significant remote and rural geography



Argyll and Bute is the second largest Council area in Scotland by area (after Highland), with the third lowest overall population density in Scotland (after Highland and Na h-Eileanan Siar) [2].

47% population live in 'Rural' areas (2020) [2] [5].

Helensburgh is relatively well-connected via land transport links with the central belt and is the only settlement classified as 'Urban' [5].

69% population (live in 'Very Remote' areas (rural or small towns) (2020) [2] [5].

45% of small areas are within the most access deprived in Scotland [6].

23 inhabited islands at the 2011 census [7].

There is a lower ratio of people of working age to other ages in remote and rural areas [9, p. 13] [2, p. A1.5].

Deprivation and Poverty

– associated with poorer health and wellbeing [9, p. 40]

1 in 10 of the population are estimated to be income deprived (9.7%), lower than for Scotland as a whole (12.1%) [6]. 17% of the population of Bute are estimated to be income deprived with Cowal (13.2%) and Kintyre (13.2%) also having a higher proportion than Scotland as a whole [6].

There is fragility in the economy in Argyll and Bute due to reliance on part-time and seasonal employment [13] [2, p. A2.6] [69].

Small areas within the most deprived 20% in Scotland can be found in parts of Campbeltown, Helensburgh, Hunter's Quay, Dunoon, Rothesay and Oban. Bute, along with Helensburgh, have small areas within the 20% least deprived in Scotland [6].

Deprivation within rural areas is likely to be hidden by the mixed socioeconomic status of small rural areas [14]; 76% of those identified within Argyll and Bute as being income deprived do not live in one of the most deprived 20% of areas in Scotland [6] [2, p. A2.5].

17% of those aged under 16 (2,215 children) are estimated to be living in relative poverty (2019/20) in Argyll and Bute [16]. Child poverty has long-term implications [15] and the proportion living in relative poverty has increased since 2013/14 in Argyll and Bute alongside the rest of the UK [16].

Minimum income standards (the income needed to afford 'essential' items) is high in remote, rural and island areas [17]. A factor in this is higher fuel costs; Argyll and Bute has high rates of fuel poverty in comparison to Scotland [18].

LIFE CIRCUMSTANCES

Trauma experience

Childhood experience of trauma is associated with poorer health and wellbeing outcomes [8] [11].

160 children (aged 0-17) in Argyll and Bute are classified as looked after (5-year average at 31st July 2016-2020) [19].

49 children were on the child protection register (at 31st July 2020) [19].

177 children were referred to the children's reporter in 2020/21. Some were referred more than once resulting in a total of 228 referrals, 39 of which were for an offence [20].

687 reported incidents of domestic abuse (2019/20). Reported rates have increased since 2003/04 are lower than for Scotland [21].

Although crime rates are relatively low, they are higher in more deprived areas [2, p. A2.12]. People with unmet Health and Social care needs can impact on Police Services.

The impact of trauma experience can be mitigated against [8].

Housing

Over 1 in 5 live alone and this is projected to increase (NRS) [9, p. 15] [2, p. A2.10].

The balance of care between residential or in the community has already shifted considerably towards looking after people at home [2, p. B3.11]. 52.8% of those age 65+ with long term care needs (10+ hours home care per week) were looked after at home (2018/19) [22].

Our housing needs assessment provided evidence of need for adaptations to support independent living at home [2, p. A2.10] [23].

There is evidence for need for affordable housing in some areas, which may be a barrier for the HSCP workforce [24].

Argyll and Bute has high rates of:

- Empty properties in some areas
- Second homes in some areas
- Older housing stock

100 homeless application a year (the majority of which have support needs) [2, p. A2.10].

LIFE CIRCUMSTANCES

Seasonal factors

Argyll and Bute has an increased temporary population in the summer months; this likely occurs both from tourism and longer stays in second homes [2]. Mortality increases in winter months as for Scotland as a whole [25].

Unpaid care

As there are more people living with limiting conditions, the number of unpaid carers has increased [9, p. 71]. Unpaid care can impact on carers own health and wellbeing [26].

Carers, including young carers, may not identify themselves as such [2].

As many as **12,000** people aged 16+ provide unpaid care in Argyll and Bute with the highest proportion estimated to be residing in Bute, Cowal and Kintyre (estimated using Scottish Health Survey results and population estimates) [2].

Climate

Climate change is a challenge that may impact health and wellbeing through several routes including through extreme weather and flood risk, changing disease risk, air pollution, migration and food security and it is likely to have greatest impact on those already vulnerable [28] [29]. With many island and coastal communities, parts of Argyll and Bute are more at risk of the impact of adverse weather events and disruption to transport networks including ferry travel and coastal roads. A new 2022-2026 climate emergency and sustainability strategy for the NHS in Scotland is being developed [30] .

CHALLENGES

- Accessibility of services for all including across a significant remote and rural geography
- Prevention and mitigation of poverty and deprivation
- Prevention and mitigation of trauma experience
- Increasing numbers of people living alone and social isolation
- Need for housing adaptations to support independent living at home
- Seasonal fluctuations in demand
- Impact of unpaid care on carers
- Impact of adverse weather and reducing our carbon footprint and waste

HEALTH AND WELLBEING STATUS

Life expectancy at birth (2018-20)[31]

Life expectancy is slightly higher in Argyll and Bute than for Scotland as a whole [4].

Increases in life expectancy that were observed before 2012-2014, have slowed down (stalled) since 2012-2014 [2, p. A3.2] [9, p. 19] [32].

Inequalities

That female life expectancy is higher compared to male life expectancy is an example of an inequality (an unjust and avoidable difference) [33] . Another is that life expectancy is lower in those living in the most deprived compared to least deprived areas [9, p. 57] and that the stalling of increases in life expectancy since 2012-2014 have been particularly in those living in the most deprived areas, with evidence linking this to austerity measures [32].

- **People who live in areas with higher rates of poverty are more likely to:**
- Have babies with a low birthweight [9, p. 46]
- Be overweight or obese when starting Primary One [9, p. 48]
- Be admitted to hospital with asthma [9, p. 53]; COPD [9, p. 54]; a mental health problem [9, p. 55] and to have a potentially preventable admission for a chronic condition [9, p. 56] [2, p. A3.8]

People who live in areas with higher rates of poverty are less likely to:

- Be exclusively breast feeding at the 6 - 8 week review [9, p. 47]
- Take up bowel cancer, breast cancer and aortic aneurysm screening [9, p. 49]
- Live as long as people in more affluent areas [9, p. 57] [2, p. A3.8]

The NHS Highland Director of Public Health's Annual Report for 2019 [9] also highlights that:

Gypsy / Traveller people have the worst health of any ethnic group in Scotland.

LGBTQ+ people have worse health outcomes on average, and 14% report avoiding healthcare because of fear of discrimination.

People with learning disabilities are more likely to experience low incomes, poor housing, social isolation and loneliness, bullying and abuse than people who do not have a learning disability.

330 adults with learning disabilities were known to Argyll and Bute Council (2019) [37].

HEALTH AND WELLBEING STATUS

Long term conditions

Scottish core survey results indicate that **1 in 4** adults in Argyll and Bute are living with a limiting long term physical or mental health problem [34][35]. This proportion increases with increasing age.

Through records of service use, Public Health Scotland estimates **24%** people in Argyll and Bute are estimated to be living with a physical health condition, the most common of which is arthritis [4]. The proportion of people with multimorbidity (the presence of 2 or more conditions) increases with increasing age.

ScotPHO burden of disease study (2019) [36]

Highest burden of disease, by broad disease groups:

- Through early mortality: cancers and cardiovascular diseases
- Through disability: mental health disorders and musculoskeletal disorders

Highest burden of disease by individual causes of disease:

- Through early mortality: ischaemic heart disease, lung cancer, Alzheimer's disease and other dementias, cerebrovascular disease, 'other cancers', drug-use disorders, colorectal cancer, chronic obstructive pulmonary disease, 'self-harm and interpersonal violence' and lower respiratory infections.
- Through disability: low back and neck pain, depression, headache disorders, anxiety disorders, osteoarthritis, diabetes mellitus, cerebrovascular disease, 'other musculoskeletal disorders', 'age-related and other hearing loss' and alcohol use disorders.

The prevalence of many conditions varies by age with the highest burden of disease for those under 15 including congenital birth defects and asthma.

Long term conditions

Some conditions are likely to be under-diagnosed including: [2, p. A3.7]

- Dementia
- Hypertension
- Type II diabetes

Due to increased number of older people and improved survival for some conditions, our DPH report [9] and HSCP needs assessment [2] indicate likely future increases in:

- New and existing cancer diagnoses [9, p. 28]
- Musculosketal and orthopaedic problems
- Type II diabetes [9, p. 31]
- Dementia [9, p. 37]
- Frailty [9, p. 36]
- Sensory conditions associated with older age
- Children and younger people with care needs [8, p. 29]
- Multimorbidity

HEALTH AND WELLBEING STATUS

Frailty is associate with older age and people with frailty are more vulnerable to adverse outcomes following a relatively minor change or event. **14%** of those 60+ in Argyll and Bute have been estimated to be frail, but this proportion increases with age considerably by age [9].

Crude rates of falls rates in Argyll and Bute are higher than for Scotland, which might be partially accounted for a higher proportion of older people in Argyll and Bute [4]. However, admission rates due to falls for those in specific older age bands e.g. 75-84 and 85+ are also higher in Argyll and Bute [38].

Mental health and illness

19% prescribed drugs for anxiety, depression or psychosis (2019/20) and this proportion increased in recent years up to 2019/20 [23] [5]

Almost **50%** of girls in S4 had abnormal/borderline scores on the Strengths and Difficulties Questionnaire (SDQ) (a measure of Mental Health), asked as part of the Scottish Schools Adolescent Lifestyle and Substance Misuse Survey (SALSUS) [3]. In the 2018 included participation from every secondary school in Argyll and Bute, achieving a more robust sample than in previous years [3]

Admissions due to intentional self-harm in young women (age 15-24) [40].

Suicide

66 suicides were reported in Argyll and Bute (2016-2020) [47] with higher rates in males compared to females and in the most deprived compared to the least deprived areas [41].

Challenges

- Increasing numbers of people with care needs
- Tackle (reduce) inequalities in health and wellbeing
- Management of people with one or more long-term conditions
- Prevention of long-term conditions
- Under-diagnosis of certain conditions
- Accessibility of services for those with sensory conditions
- Mental health support e.g. through mental health first aiders, trauma informed communities and training in suicide prevention.

BEHAVIOURAL FACTORS

As well as deprivation and life circumstances, age and genetic risk, behavioural and metabolic/ clinical risks influence health and wellbeing [4, p. 33] [2, p. A4].

Smoking

14.5% adults in Argyll and Bute are estimated to smoke (95% confidence: 11.1% – 17.8%, 2019) [42]. This has been decreasing but is higher in more deprived areas.

Physical activity, diet and healthy weight [43]

< 1 in 4 (22%) of adults within the Highland Health Board area eat 5 or more portions of fruit or vegetables a day (2016-2019).

66% females and **73%** males meet recommendations for physical activity (2016-2019).

Over a quarter (**28%**) of adults within the Highland Health Board area are obese (BMI 30 or higher, 2016-2019) [43].

75% of children in P1 with healthy weight, lower than for Scotland as a whole (2019/20) [23].

Alcohol and drugs

Hospital stays due to **drug use** in Argyll and Bute have increased in recent years and are more likely in the most deprived areas. Drug-specific deaths have also increased [5] [23].

23% of adults are estimated to drink at hazardous/harmful levels (2016-2019) [43].

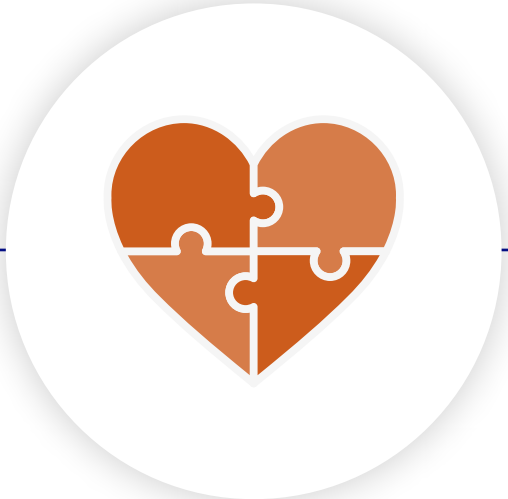
Sexual Health [46]

Health Protection Scotland reported, up to 2019 a reduction in new HIV infections and a reduction between 2018 and 2019 in Syphilis infections, albeit from a peak in 2018. Chlamydia and Gonorrhoea infections show increases in recent years [45].

Rates of teenage pregnancies have been falling [44]. Reducing unintended teenage pregnancy remains a priority for the Scottish Government.

Challenges

- Enable and support behaviour change to reduce risk behaviours
- Address risk factors and inequalities in risk behaviours



IMPACT OF COVID-19

Harms due to COVID-19 can be caused both directly by the disease but also indirectly by changes to or reductions in other health and social care services, by the impacts of social distancing measures or by the economic impact of the pandemic. The Scottish Government has set out what it refers to as the Four Harms of COVID-19 [48]:

1. Direct Health Impact of COVID-19:

The direct impact of COVID-19 refers to the impact of having COVID-19. This includes the disease, hospitalisation, death and long COVID.

16,294 people had tested positive for COVID-19 in Argyll and Bute up to 27th February 2022, which is an underestimate of the total number of people who will have been infected with the virus [52]. The rate per head of population who have had a positive test (19,072.9 per 100,000) is lower than for Scotland (25,448.2 per 100,000).

Sadly, **140** residents of Argyll and Bute have been registered with COVID-19 as any cause of death (occurring between 01 March 2020 and 31 January 2022), for which COVID-19 was the underlying cause in 120 deaths [51]. This is a lower age standardised rate (66.4 per 100,000) than for Scotland (109.5 per 100,000). Rates of death involving COVID-19 have been higher for older people, for those living in the most deprived compared to least deprived areas and in urban compared to rural areas.

The number of people with long COVID in Argyll and Bute is uncertain. Scottish Government modelling projects that, on 6th March 2022, between 1.1% and 2.9% of the population of Scotland would self-classify with **long Covid** for 12 weeks or more after their first confirmed (or suspected) infection [50].

2. Other health impacts:

Other health impacts refers to the impact on delivery and use of health and social care services other than those related to COVID-19.

During the first national lockdown and subsequently, NHS service use reduced in many areas including [48] :

- A&E attendances
- Planned and emergency hospital attendances
- GP attendance

Change in service use could be due to some or all of the following [53]:

- Reduced need
- Reduced demand
- Reduced availability

Waiting lists for new outpatient appointments across Scotland are 49% higher at end December 2021 than end December 2019 [54].

Waiting lists for inpatient or day case admissions across Scotland are 50% higher at end December 2021 than end December 2019 [54].

Excess Deaths

Across Scotland, deaths in 2020 and 2021 exceeded the average for 2015-2019 by 11% and 10% respectively [57]. Around a third of the excess deaths in the first wave were not attributed directly to COVID-19 [53] [56] [55]. In Argyll and Bute, there were 6% more deaths in 2020 than the average for 2015-2019 [57].

IMPACT OF COVID-19

3. Societal impacts:

Societal impacts, relating to restrictions put in place to reduce the spread of the virus all impact on health e.g. through isolation or anxiety.

Harm to children through missing **education** and contact with others is likely to impact most greatly on those from families on lower incomes [58]. There is evidence of an increase in domestic abuse through lockdown [59] and an increase in households applying for crisis grants [60].

Although not felt by all, negative impacts on **mental health**, including deterioration for those with mental health conditions have been described [61], including on children and young people [41, p. 42]. Reported survey data showed high levels of concern over the threat of losing employment [48]. Emerging evidence suggests that physical activity, diet and weight have also been affected [62]. Harm due to substance use may also have increased [63].

There is evidence that those with disability and those asked to shield have also been negatively impacted in many ways including reduced physical activity and increases in anxiety [64]. Older people have experienced increases in **frailty and deconditioning** due to lack of physical activity and increases in cognitive decline [65]. Many **unpaid carers** have lost support but taken on more burden of caring [66].

Health and social care staff, and other keyworkers are likely to have experienced increased pressures at work [41, p. 43].

Some groups are more likely to be negatively affected by restrictions and changes due to COVID-19, widening already existing inequalities in health and wellbeing. Identified groups more likely to experience indirect harm due to COVID-19 include [67]:

- Young people (18-25)
- Women
- People on low-income
- Families with children
- Older People
- People with mental health problems
- People who use substances or who are in recovery
- People with a disability
- People who are homeless
- People in the criminal justice system
- People who are part of the Black, Asian and Minority Ethnic (BAME) community

4. Economic impacts:

The economic impact of COVID-19 is also relevant to health and wellbeing. Many measures of health and wellbeing show an association with poverty or socioeconomic status. Those experiencing reduced income or uncertainty around income may be more at risk of harm to health.

The economic impact of COVID-19 included a large decrease in Gross Domestic Product (GDP) and reductions in employment and income [48].

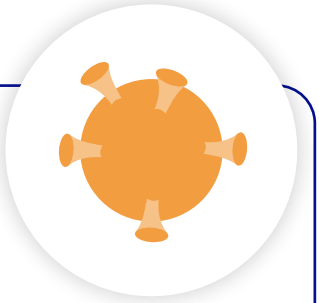
The economy of Argyll and Bute, with a reliance on the tourism industry, may make it particularly vulnerable [68]. The economic impact of COVID-19 is unequal, with those on low incomes and in seasonal employment most at risk and generating widening inequalities in income and employment [67]. There are many links between income, employment and health4 and greater inequalities in income are associated with overall poorer health[1]. Child poverty, which can have long lasting impact on health and wellbeing across the life course, is likely to increase.

IMPACT OF COVID-19

Summary

COVID-19 has, in many ways, impacted most where there was already need e.g. increasing existing inequalities, impacting mental health and wellbeing and increasing waiting times for services. Responses to the pandemic have further accelerated existing changes towards care at home and remote delivery of services e.g. use of online tools to deliver online consultations. There remains uncertainty over the longer term impact of COVID-19.

Evidence for the impact of COVID-19 is still emerging and the full impact is likely to take more time both to occur and to be evidenced.



Challenges

- Impact experienced unequally
- Increase demand for services due to lower uptake during pandemic
- Increased trauma experience
- Staff mental health and wellbeing
- Impact on unpaid carers
- Frailty and deconditioning
- Continuing uncertainty

COMMUNICATION AND ENGAGEMENT

Challenges

- Collated feedback from previous engagement activities suggests a need to improve engagement with the public [2].

ENGAGEMENT - WHAT YOU TOLD US

A single 'Engagement and Communications Action Plan' was developed for both the JSCS and the HSCP Joint Strategic Plan to act on the declared vision that:

> **We want to ensure that everyone has the opportunity to input into the future shape of health and social care services. We want to know the stories of how Covid has affected people and what we can learn from experiences.**

Identified stakeholders were invited to events planned in collaboration with the ihub – Transformational Redesign Unit (Strategic Planning Portfolio) of Healthcare Improvement Scotland. Online formats, including novel formats for the HSCP (Google Jamboard, Slido and the use of live and recorded webinars) were chosen due to COVID-19 restrictions. The table below describes the numbers of participants.

What's working? What's not working?
Think creatively, what would you do?

Stakeholder Group	Service Areas	Format	Participants
Staff	Adult Services*	Conversation Café and Jamboard	35 incl 3 facilitators
Staff	Adult Services*	Conversation Café and Jamboard	15 incl 3 facilitators
Staff	Learning Disabilities & Physical Dysabilities (LD&PD)	Conversation Café and Jamboard	17
Staff	Mental Health & Addictions (MH&A)	Conversation Café and Jamboard	31 incl 2 facilitators
Staff	All	Survey 1 (S1)	16
Staff	All	Survey 2 (S2)	89
SPG	Strategic Planning Group	Conversation Café and Jamboard	27 incl 3 facilitators
Providers	Commissioned Third and Independent sector Providers	Conversation Café and Jamboard	30
Providers	Care homes and at Care at Home Providers	Conversation Café and Jamboard	31
Public / Open	All	Joined Live Webinar	36
Public / Open	All	Watched Replay Webinar	21
Public / Open	All	Joined Slido: active users Slido Poll:	60 | 51
Public / Open	All	Online Survey	24

What: What has happened in the last 3 years? Where are we now? What has been the impact?

So what: What have we gained? What have we lost? What shifts are needed? What are priorities?

Now What: How do we take this forward?

Please share your Questions, Comments and Ideas

From what has been heard today what are the questions and issues you wish to raise?

What do you see the main developments in your area over the next 3 years?

How do we foster collaboration over the next 3 years?

DRAFT PRIORITIES

Staff surveys survey respondents were more likely than not to indicate that the draft priorities were meaningful and that they were aspirational and ambitious

Priorites	Meaningful 75% (n=87)	Aspirational and ambitious 66% (n=88)

Source: Saff Survey 2 results

Saff Survey 1, combined Priorities and Commissioning Intertions: 60% meaningful (n=15) 40% Aspirational (n=15)

Comments received from across the staff and provider feedback supported priorities relating to **Prevention and early Intervention** as well as **Choice and Control**

> I work in the field of Learning Disability and all of the above will enhance and improve the quality and quantity of life for those I support
>
> Staff

> Access to choice of social care services across the whole of A&B. Too many area's have no services available
>
> Public/Open

> Agree with priorities. Great that Prevention and Early Intervention are right at the top
>
> Providers

> Early intervention is crucial for families under pressure to reduce further risk and future crisis
>
> Staff

> I think you have choice & control spot on
>
> Staff

Results from the public survey, although from small numbers of people, provided evidence for potential for improvement in areas related to the priorities

Only 2 out of 19 people in the public survey reacted positively to:	You / They were made fully aware of the community organisations locally where you / they could access support

> I believe they are what we should already be doing
>
> Staff

> Definitely aspirational as there is no money for early intervention services
>
> Staff

Challenges to the proposed Priorities and Commissioning intentions were that they:

- Comprise buzz-words/ difficult language (co-production needs to be defined)
- Are unattainable/unrealistic or difficult to achieve
- Need action to achieve them
- Need to be specific and measurable
- Should be done already

> Language seems cliche'd and unauthentic
>
> Staff

> They're quite inarguable as broad principles. For them to be truly meaningful, they will need to measurable and linked with goals at clinical team level
>
> Staff

WHERE WE ARE NOW

Across the consultation, the contribution of individual people/ staff was strongly recognised.

> The people - always the people do their best
>
> Public/Open

There was recognition of significant changes to services implemented over the course of the previous strategic plan and changes within HSCP senior management.

All areas of engagement acknowledged the impact of COVID-19:

Negative impacts on staff and staffing (including burn-out and shortages)

- Stretched services (including increased waiting times)
- Increased use of technology
- Shift of balance of care to the community
- COVID-19 impact of health and wellbeing of the population
- Increase in service appreciation

Although benefits were seen with the use of technology, feedback also cautioned regarding the impact of digital exclusion and need for face-to-face service provision.

> Staff seem exhausted, less motivated and some have left the services. Contracts haven't been renewed, so families unable to find who is now managing their case
>
> Public/Open

> Travel is essential to access many services for A&B residents much of which requires travel to specialist services in GG&C
>
> Public/Open

The most common challenges with accessing HSCP services, as described in the public consultation were:

- **Long waiting time**s (49% Slido respondents and 35% of survey respondents)
- **Lack of service availability** (over 30% in each consultation method)
- **Travel required** (over 30% in each consultation method) was highlighted by over 30% in each consultation method. Over 30% Slido respondents highlighted
- **Lack of face to face provision** (over 30% Slido respondents) and over 30% Survey respondents highlighted
- **Lack of communication from services** (over 30% Survey respondents)
- **Difficulties knowing what services are available and how to access them** (over 30% Survey respondents).

> Some parts of argyll and Bute have more services than others. More rural areas, staff seem to struggle to cover basics
>
> Public/Open

Comments from survey respondents highlighted travel to GGC for specialist services and difficulties providing rural service provision. Staff shortages and services gaps were also highlighted.

Current gaps with services was a theme that was repeated in Public, Provider and Staff engagement feedback.

> No specialist services in the area people have to move out of area and they can't move back. Even areas within Argyll and Bute are a long way from each other and family/ community connections/ Staff
>
> Staff

> No nursing home in Oban area, which needs to be looked at
>
> Public/Open

> Crisis in private care provision (POC's)
>
> Providers

> Not enough providers so not much choice of service
>
> Staff

> This is all well and good but the services to support this to happen for young people after diagnosis aren't there? For example if you have a child diagnosed with autism where is the training for parents around this?
>
> Staff

> I think the HSCP do not understand how vastly different service delivery is across the area
>
> Public/Open

> Why are so many people going out of area, are there not the numbers of places available in argyll and bute
>
> Provider

> Not enough flexibility to 'wrap around' someone leaving hospital or in crisis in community
>
> Staff (CS)

> Gap in responder hours can be an issue for clients with dementia
>
> Staff (OA&D)

Shortages in staffing was a key theme repeated across different areas, particularly within social care but also affecting other staffing groups.

> Flow of patients through the hospitals- delays in being discharged have resulted in real harm/ deterioration of the individual
>
> Staff (Hosp)

> Massive problem with shortage of carers to provide care at home causing delayed discharges in hospitals
>
> Staff (CS)

> Staffing barrier to SDS, great need but small population of workers
>
> Providers

> What is your plan to get more carers ie Home Care Dunoon is in urgent need of Carers, Families cant get packages What is your Plan
>
> Public/Open

The ongoing financial pressures faced by health and social care services was recognised but also, particularly in relation to commissioning, providers highlighted the difficulties with short-term and insecure funding arrangements.

> Services are really under pressure with constant re-structuring or transformation, budget cuts and staff shortages
>
> Staff survey

> It may take some time for providers to build up any trust in the words offered by Senior Partnership Personnel however I believe this may change if the Partnership show they have listened and offer care at home providers financial stability instead of the current spot purchase agreement
>
> Providers

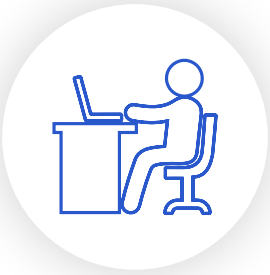
> We need seed funding to allow us to inact changes in commissioning but not stop what we are doing at the same time
>
> Staff (SPG)

Financial pressure from an individual perspective also had an impact on **choice.**

> Direct payment rates for option 2 don't cover cost of most providers so only choice is option 3 or topping up themselves. If areas are mapped to providers there is no choice at all
>
> Providers

Staff highlighted difficulties with **building space/infrastructure.**

> MAKI office space not fit for purpose. Ongoing longstanding issues
>
> Staff



> Modernising our facilities to ensure they are fit for purpose and ready for the future
>
> Staff (SPG)

This included some perceived limitation in specialist accommodation in the community.

> Not enough suitable accommodation in local areas for Dementia clients
>
> Staff

> Very limited supported living in A and B
>
> Staff (MH&A)

Work culture

There was acknowledge of the focus on work culture after the Sturrock review, with comments highlighting need for further work in this area.

> Not sure if it's possible but perhaps find a way to help each profession to understand the work of the other professions. Help them understand the tasks involved and the unique pressures of each workplace and work type
>
> Staff

> How do you wish to address the challenges of "hierarchy" between health & social care? -from observation whilst there may be efforts to have integration it is a un-balanced see-saw
>
> Public / Open

> Value and celebrate staff input in all sectors, supportive working environment
>
> Staff

THE FUTURE

Principles of providing services to support people were present in themes across all the engagement conducted

Need for **good communication** with clients and partners

> What happened to the consultation work that was done a few years ago in OLI around this provision? A day spent discussing options and considering implications of each. Felt like time well spent but no follow-up?
>
> Public/Open

> Co-production of services to fit local needs, preferences and available resources
>
> Public/Open

> Client and family expectations - improved management, clearer provision of what is provided and not provided by carer's, within a package of care
>
> Staff (Hosp)

Joint working – with partners and community groups

> Re-alignment and more equitable opportunities between external and internal providers
>
> Providers

> Barriers as cannot share information with commissioned providers, can we not share support plan and assessments with care providers
>
> Staff (Hosp)

> Better community integration, possibly with more 3rd sector input
>
> Public/Open

Geographical accessibility (and transport)

> OLI is a very rural area with the islands included, so other issues affect this area, travel time etc
>
> Providers

> Transport issues across the localities
>
> Staff

> Better local access to services
>
> Public

> Providing care locally to needing it, reducing patients having to travel to access care
>
> Staff (Hosp)

Person centred – continuity of provision from a client perspective

> Shifts - need investment focus on outcome of individuals and not follow old patterns of service provision
>
> Staff – (SPG)

> People are people. A person-centred approach, provided by well-trained and multi-skilled workers surely leads to positive outcomes, rather than fixating on client groups and assuming that people with a certain health condition or impairment have presumed similarities
>
> Providers

> Ensuring that vacancies are filled quickly, so we know who to contact
>
> Public/Open

Respite from **unpaid care/support for carers**

> Ensure that all those involved in public interface and decision making fully understand and are committed to implementing the above mentioned Acts. (Statutory Guidance for the Self-directed Support (Scotland) Act 2013, and the Carers (Scotland) Act 2016)
>
> Providers

> Lack of respite resources for carers to give them proper breaks away from caring role
>
> Staff (OA&D)

Quality, safety, governance

> Some HSCPs require a brief 4-weekly return covering KPIs as part of the contract monitoring process
>
> Providers

> Greater focus on outcomes and linking resource consumption and allocation to the impact we make on people lives rather than focussing on inputs
>
> Staff (SPG)

> Better community care. Improve home care. Make social work staff more
>
> Public/Open

Staff and public had suggestions relating to the model of care between community and hospital including:

- Step up and down provision
- Intermediate care
- Core and cluster models
- Hospital at home services

> Hospital at home and staff outreaching if we had more staff to do this, would improve links for both Community and hospital
>
> Staff (Hosp)

> Redesigning older people care home/care at home services to be more core and cluster where appropriate
>
> Providers

> Third sector home from home community options to offer support rather than admission
>
> Staff (MH&A)

> Struan Lodge were doing step up step down a number of years ago. We are situated next to Cowal community Hospital this should be reinstated
>
> Public/Open

FEEDBACK ABOUT THE CONSULTATION

There was feedback on the consultation itself. The limitations of the consultation in the low response rates for the public survey and need for continued engagement was also highlighted.

> Keep jamboard running permanently for suggestions - as long as there is feedback to know this is being listened to - even if don't always agree
>
> Staff

> 28 people to date, in a population of more than 80,000, partaking in a poorly designed poll, is of limited utility. It would be good to hear ideas of more meaningful consultation.
>
> Public/Open

> How do you plan to build partnerships with local "island" communities? You say it is an 'important conversation
>
> Public/Open

> This webinar seems to focus on older adults. What about adults with personal problems or relationship/ family issues?
>
> Public/Open

> More discussion about what is actually needed in the area - its not one size fits all
>
> Public/Open

REMOBILISATION

The remobilisation of services across both health and social care is a Scottish Government priority and frontline staff and managers are working hard to achieve this across the Health & Social Care Partnership (HSCP).

The success of the vaccinations programme has reduced deaths but the ongoing impact of responding to variants of Covid-19 has created a growing backlog of patients waiting much longer for treatment. The HSCP has developed a remobilisation (recovery) plan to reduce the backlog and transform how care is delivered to meet our population need.

The plan will focus on creatively adding additional activity into the system and have a robust waiting list management system ensuring that the most urgent patients receive their care first.

Risks to our remobilisation

- Uncertainty about how the Covid-19 pandemic will develop and the potential impact of future surges on the NHS
- Workforce issues, including the need to make sure that staff have time and support to rest and take leave and concerns about sustainability because of retirals, recruitment challenges, redeployment and having the appropriate skills mix Covid-19
- Concerns about the longer-term impact of Covid-19 on the population and the way in which health and social care services will be delivered. Examples include the resources needed to further develop the role of public health services; the ongoing need for enhanced infection prevention and control measures; and the impact of unidentified and unmet healthcare needs on the demand for services.

The HSCP also plan to introduce a centralised booking service to ensure that patient pathways are appropriate, any variances can be addressed, access is improved for patients and resources are maximised leading to reduced waiting times. A centralised booking service would improve service accessibility and patient care through redesigning:

- Physio / MSK Virtual service (Orthopaedic redesign)
- Ophthalmology imaging hubs and referral onwards to GGC virtual Ophthalmology service
- ENT service where LIH is potentially the hub for all diagnostics including naseo-endoscopes and increased use of Audiology to support virtual appointments/ treatments

Shift to virtual consultations:

- During the Covid Pandemic we have seen an increased shift in the increased use of technology and patients utilising alternative pathways of care and accessing virtual appointments, either via NHS Near me or telephone, patients can also access consultants from other sites using this technology.
- It is vital that as part of the remobilisation the HSCP harness these opportunities to embed and enhance these new ways of working as the blended “norm” where possible and we need to set an ambitious but realistic target across all clinical specialties including AHPs. The NHS Near me infrastructure continues to grow, the TEC team are supporting clinicians to use it and look to further work with NHS Greater Glasgow and Clyde to support the pressure specialities.

TRANSFORMATION AND SERVICE REDESIGN - HOW WILL WE GET THERE?

See Apendix 13- Performance Monitoring for details on how areas will measure progress

CHILDREN'S SERVICES

Current Situation

A vision for children and young people was published last year which is collectively known as 'The Promise' This promise ensures that, over the next ten years, the service will endeavour to ensure that, where possible, children stay with their families and families will be actively supported to stay together. Children and young people will be listened to, respected, involved and heard in every decision that affects them. Where intensive support is needed it will be given in timescales which meet the needs of the child. This is immediate and will be the focus over the period of this plan.

As Corporate Parents, we hold the highest level of commitment and ambition for all our care experienced children and young people. We want our children and young people to have the best possible start in life and for Argyll and Bute to be one of the best places in Scotland to grow up.

We recognise that investment in our children and young people is one of the most valuable long-term investments that we can make. By investing our shared resources in the delivery and development of services that focus on prevention and early intervention, we can ensure that children and young people's needs are met at the earliest opportunity and they are supported to achieve their full potential.

This includes our main focus on promoting children and young people's wellbeing underpinned by Getting it Right for Every Child (GIRFEC) and by adopting preventative approaches dedicated to the needs of children and young people at the earliest possible time. Recognising the importance of children and young people achieving and maintaining good physical and mental health and wellbeing is also paramount.

Challenges

Up to 2020, Argyll and Bute had one of the lowest rates of care experienced children of any Scottish Local Authority. However, since then there has been an increase of 10% while the average increase across Scotland was 4%. Early findings suggest this is a result of the Covid Pandemic.

In addition, Child Poverty continues to be a priority for the Service. The latest statistics for child poverty in Argyll and Bute are that 20.4% of children in our area are in low income households. The Child Poverty (Scotland) sets targets for child poverty for Scotland for 2030 to have less than 10% in relative poverty and 5% in absolute poverty. Current statistics show that of our population, 41,738 people are amongst the 15% most access deprived and more than 10% are in the most deprived areas

How has Covid affected your past and future intentions and priorities?

Before the pandemic, Argyll and Bute had one of the lowest rates of care experienced children of any Scottish Local Authority. However, comparing our increase against the Scottish average we have seen an increase in 10%. This has put particular pressure on the residential high cost care budgets from external placements; It has also resulted in some of our transformation aspirations being delayed. This is evidenced in a change programme to look at changing the balance of care model across the HSCP from external to more fostering.

A number of children disabilities services have had to close due to the pandemic, this has caused financial sustainability pressures for some of our service providers; this has also resulted in delays in completing reviews to ensure that these services are delivering best value outcomes.

The service is focussing on its remobilisation plans and is early in its evaluations of specifically identifying the full impact of the pandemic.

CHILDREN'S SERVICES

What have we done so far?

- We have engaged widely and published a new Children and Young People Service Plan, developed and published a new Corporate Parenting plan, developed a multi-agency approach in drafting and implementing a new Children Services Commissioning Plan. This work is being implemented and is well established and is driven by a robust multi-agency approach.
- Our 3 Children's Houses as well as our Adoption and Fostering Services are graded 5 (Very Good).
- We have developed and gathered feedback survey to be circulated to S2 and S4 school pupils.
- 100% of our Young People leaving care in the last year were offered appropriate housing.
- We have fully embedded all elements of the Universal Health Visitor Pathway.
- We are using the Model for Improvement to test the use of assessment tools and interventions aimed at supporting Children to reach their developmental milestones at 13 – 15 months and 27 – 30 months.
- We are also using the Model for Improvement to test methods to ensure multi-agency chronologies are in place for Children and Young People following an Initial Referral Discussion (IRD) where the decision is to progress to child protection procedures.
- We have initiated a redesign of the Child and Adolescent Mental Health Services (CAMHS) including the deployment of additional staffing which will ensure a clear and accessible pathway is available to all young people in secondary school.
- We have developed GIRFEC (Getting It Right For Every Child) infomercials by young people for use in schools to promote understanding of the Named Person role and the National Well-being indicators.
- In line with "Best Start" we provide continuity of Midwifery care to women across Argyll and Bute.

What do we plan to do?

- We will ensure Children and Young People are provided with opportunities to evaluate current services and influence the planning of future services.
- We will ensure that what matters to children and families are at the heart of change.
- We will ensure that services actively listen to families and provide a whole family support service.
- We will ensure that planning, investment and information is shared widely.
- We will ensure that our workforce is supported and focus will be on building capacity for long term sustainability.
- To ensure that the focus for change is aimed at addressing child poverty and within a context of Children's Rights agenda.
- We will implement the redesign of CAMHS (Child and Adolescent Mental Health Services) to improve access to and the responsiveness of local community based services.
- We will oversee and align the self-evaluation of services involving Children and Young People under the Children and Young Peoples Services Plan to provide greater uniformity when identifying multiagency and single agency performance measures.
- We will place Looked After and Accommodated Children (LAAC) closer to their families and communities.
- We will ensure young people's views are listened to and acted upon.
- We will make greater use of the Model of Improvement to ensure long term sustainable changes are embedded in practice.
- We will prevent Children and Young People coming into care through prevention, early intervention and effective alternatives.

CHILDREN'S SERVICES

Priorities Year 1

- Continue to deliver on the Children and Young Peoples Service Plan.
- Continue to deliver on the Corporate Parenting Plan.
- Continue to monitor and evaluate progress in all our service plans.
- Develop transformation aspirations for the Service.
- Develop programme of change in relation to the Children's Promise Change programme.
- Continue to engage with Children and staff on transformation agenda.
- Evaluate the outcomes of the 2018-2021 Argyll and Bute Equally Safe Implementation Plan.
- Continue to act as a conduit for information and resources on Equally Safe / Train/ National initiatives for managers and staff.
- Develop project plan for Transforming Responses to Violence against Women and Girls Project.

Priorities Year 2:

- Implement 2nd Year Actions from Children Promise Change Programme.
- Report on Performance of outcomes.
- Deliver on the project outcomes for transforming responses to Violence against Women and Girls.

Priorities Year 3:

- Implement 3rd Year Actions from Children Promise Change Programme.
- Monitor performance of Children and Young Peoples Plan.
- Evaluate and report on service plans and transformation projects.

CHILD POVERTY

Current Situation

In 2019 we produced Argyll and Bute's first Child Poverty Action Plan; this has since been reviewed in 2020 and 2021.Fiona Davies (Chief Officer for the HSCP) is the Lead Officer on Child Poverty and a multi-agency Child Poverty Action Group (CPAG) exists to support the work outlined in the plan and to identify new initiatives to tackle the drivers and impacts of child poverty.

Challenges

The Scottish Government has set child poverty reduction targets for 2023 and 2030; a number of factors have made achieving these more challenging. Chief amongst these are the effects of the Covid-19 pandemic and the UK's withdrawal from the European Union.Many measures that can be seen to contribute to child poverty, such as the level of Universal Credit are decided at a national level but the way in which benefits are managed locally can act to provide some mitigation. The challenge is how to do this effectively within the financial and people resources that we have within Argyll and Bute. Other factors include the budgetary restraints faced by local authorities and the challenges of supporting a population that has an ageing demographic and many remote and rural places including 23 inhabited islands.

How has Covid affected your past and future intentions and priorities?

Covid-19 has had a significant impact on child and family poverty, with many families already in poverty finding their situations worsening and others having to rely on benefits such as Universal Credit for the first time.

CPAG members were unable to meet during much of 2020 due to demands on members from Covid-19 contingencies. However they engaged strongly in areas of work that were aimed at protecting vulnerable children and families including: increasing the reach and uptake of key benefits; working with the Caring for People Group; delivering food to children and supporting the work of the Argyll and Bute Food Forum; offering educational and welfare support to children and young people.

Covid-19 has influenced the direction and importance of some of the elements relating top child poverty: food vulnerability and how we meet that need; employability and what measures are in place to help parents, young people, people with disabilities and other vulnerable groups; benefits and the mechanisms to deliver these (Flexible Food Fund / Automated School benefits); method of working for partners such as Advice Services and third sector (more online and virtual); increased need to meet digital poverty.

Covid-19 will make it more difficult to reduce child poverty and meet the targets set for this by Scot Gov., in 2023 and 2030.

CHILD POVERTY

What have we done so far?

- We have developed a Child Poverty Action Plan that sets out what we are doing locally to tackle child poverty; we review this every year. This plan and other actions are guided by a multi-agency Child Poverty Action Group.
- We have engaged with children and young people via School Councils to gain their ideas and views of the plan. We have produced child friendly versions of the plan. We look to engage with community groups and are currently doing this, for example, via the Living Well networks.
- Community and staff awareness of child poverty is important, as is their knowledge of how it is being tackled in Argyll and Bute. We use events like Challenge Poverty Week to get information out via media posts and other methods. We have also developed a Council Child Poverty Website that provides information on the plan and links to key sources of support relating to housing, benefits, employability, domestic abuse etc.
- We have recruited to a child poverty and young carer project.
- We look to act across a wide range of areas, such as housing, food and fuel poverty, by having a broad range of members from those sectors. We recognise that employability and benefits are important areas and these are represented in CPAG.
- We recognise the importance of the third sector in tackling child poverty and a number of key agencies are represented in the CPAG and contribute to planned work, for example ALIenergy and TSI.
- We know that training to raise the awareness of staff about poverty is important; they need to be able to respond to service users with empathy and respect. It is also important for them to be able to ask the difficult money questions well and signpost people to where they can get support and the right kind of advice.Money Counts training has been developed for use in Argyll and Bute and will be rolled out to a wide range of staff. We have also commissioned Awareness Raising Training and this should begin to be rolled out to staff in 2022.

What do we plan to do?

- Continue to develop the Child Poverty Action Plan and work around tackling the three Drivers of Poverty.
- Develop a Data Base that allows us to measure changes in the level and nature of child poverty locally and identify groups and communities that require focused interventions from key services.
- Look at ways in which the impacts of poverty can be mitigated, seeking to identify gaps and help to create a focus on these.
- Develop and roll out Poverty Awareness Raising Training to a wide range of staff.

CHILD POVERTY

Priorities Year 1

- CPAG to continue to meet and develop actions to tackle the three drivers of child poverty.
- Look at impacts of Covid-19 and EU exit; consider what actions are required by the CPAG and its members to address these.
- Produce a formal communications and engagement plan.
- Begin to deliver Money Counts training to staff in Argyll and Bute.
- Review the Child Poverty Action Plan and assess progress on key areas of work.
- Begin to develop a Data Base to improve monitoring and focus of resources locally.

Priorities Year 2:

- Further develop the role and purpose of the CPAG and consider resource issues.
- Begin to roll out Poverty Awareness Training to staff.
- Establish Data Base and begin to use it to improve the work of the CPAG and services locally.
- Review the Child Poverty Action Plan and consider what is required to meet the Scot. Gov. child poverty reduction targets in 2023.
- Use Communications and Engagement Plan to improve community engagement with child poverty work in Argyll and Bute.

Priorities Year 3:

- Review the Child Poverty Action Plan and report to Scot. Gov. on progress on meeting their targets for 2023.
- Reassess actions and plan how the next Scot. Gov. Targets in 2030 are to be met.
- Review the Communications and Engagement Plan.
- Review staff training and development needs in the area of child poverty.
- Look at changes in Argyll and Bute over the last three years, in terms of demographics and the economy / employability. How do these changes impact on the work and actions of the CPAG and its members?

CHILD PROTECTION

Current Situation

The core business functions of a Child Protection Committee (CPC), as set out in the National Guidance for Child Protection in Scotland 2014, as applied to local needs and practice, provide a working framework for the CPC Improvement Plan:

Continuous Improvement

Policies, procedures and protocols

Self-evaluation, performance management and quality assurance

Promoting good practice

Training and staff development

Strategic Planning

Communication, collaboration and co-operation

Making and maintaining links with other planning

Public Information and Communication

Raising public awareness

Involving children and young people and their families

Leadership & Governance

The national Child Protection Improvement Programme emphasises leadership and governance as a key function of the CPC.

The improvement process described in the Plan takes direction from the Care Inspectorate's 2012 quality framework How well are we improving the lives of children and young people. The Improvement Plan sits within the wider context of integrated children's services planning and Getting it right for every child, promoting the ethos that "child protection is everyone's job", in line with the GIRFEC approach.

The actions detailed in this Plan which relate to the above strategic priorities will be monitored through a traffic light system as set out below**.**

Key items we want to deliver over the period 2021- 2023 are as follows:

- Provide clear and visible leadership of multi-agency work to identify and protect our most vulnerable children and young people.
- Continue to focus on self-evaluation and continuous improvement
- Continue to embed practice toolkits in daily practice and develop the quality of child protection plans.
- Build our joint approaches to protect and support children affected by Domestic Abuse, Parental Mental Health and Addictions.
- Improve communication and engagement with our communities.

This strategic plan is linked to the Children and Young Person's Service Plan 20-23 and the key priorities we want to deliver are:
Priority 1

GIRFEC Leadership and Communication- CPC plan is linked to our Outcome 1- CPC provides effective leadership and direction in CP and is accountable for its actions

Priority 2

Early Help and Support- Linked to our outcome4- we effectively identify children at risk and share info timorously and act together to protect them from harm Priority 3

Mental Health and Wellbeing- linked to our High Risk Work plan Priority 4

Children and Young People voices- link to Outcome 7 – engagement with children families and communities.

Challenges

- Staff availability has affected some actions being progressed timorously as a result of Covid and staff absence or diverted to Covid related activity.
- The priorities have remained the same and overall the strategic plan has progressed well in its first year, however due to staff changes in adult services we need to prioritise the progress of interface between adult and children's services.
- The service is focussing on its remobilisation plans and is early in its evaluations of specifically identifying the full impact of the pandemic.

How has Covid affected your past and future intentions and priorities?

Child Protection services have continued to be delivered by all relevant agencies taking into account national guidance on Covid-19 and risk assessments.

The CPC strategic plan continues to be progressed apart from one area where the availability of staff has been impacted by Covid-19, The Child Journey Audit, which will remain in the plan given it is a 21-23 timescale.

CHILD PROTECTION

What have we done so far?

- CPC has continued to deliver child protection training via Microsoft Teams.
- DA Pathway launched , audited and now embedded.
- New information leaflets designed by children via a competition in schools.
- Young Person Support & Protection protocol review initiated and staff and young people consulted via survey.
- Reflect & learn concept approved and 2 have been carried out so far this year.
- 100% of our Young People leaving care in the last year were offered appropriate housing.
- In line with "Best Start" we provide continuity of Midwifery care to women across Argyll and Bute.
- We have fully embedded all elements of the Universal Health Visitor Pathway.
- Audit activity has continued with 8 weekly audit of IRD and 1 CP Plan audit.
- Comms to children and parents/carers re.National 'For Kid's Sake' campaign ran twice and online safety campaigns.
- Advocacy work has continued for children on the CPR.
- CPC annual Conference on Sexual Abuse and Sexual Exploitation planned for 09/06/22.
- Monthly CPC chat lead by Lead Officer CP has continued, which promotes communication between CPC and frontline staff and managers.

What do we plan to do?

- Staff feedback via CPC members.
- Audit activity.
- Self Evaluation focus groups planned for February 2021.
- Self Evaluation focus groups planned for February 2021.
- Training carried out.

CHILD PROTECTION

Priorities Year 1

- All new CPC members will receive a CPC induction pack and will meet with Lead Officer to discuss the role of the CP and expectations of CPC members All CPC members will attend CPC development sessions to contribute to the role and function of the CPC members will be required to demonstrate through the delivery of the CPC improvement plan that information is being disseminated within their organisation and that actions attributed to their organisation are progressed and reported to CPC.
- Produce and implement a biennial strategic improvement plan which will be monitored by the PQA using a RAG system. Red actions will be reviewed by PQA and reported to CPC.
- Multi agency training will be delivered using a tiered approach to learning which will include: General contact workforce, Specific contact workforce and Specialist contact workforce.
- Develop and implement training framework which supports practitioner knowledge and confidence in working with CSA which includes CSE and child trafficking.
- DA Guidance and Flowchart implementation to be evaluated and regular audits of referrals to be carried out.
- Improved interface between children & adult services particularly where parental mental health substance misuse and domestic abuse are present.
- Advocacy services will engage with children on the CP register to understand their experience and to provide the CPC with recommendations as to how things can be improved.

Priorities Year 2:

- Local ICR/SCR guidance will be updated to reflect changes in national practice and to provide practitioners with clear learning pathways (this work will be undertaken with APC colleagues.
- Receive, evaluate and act on performance and QA reports CPC & PQ&A Quarterly CPC will have a framework to implement good practice and develop QI approaches to improvement based on existing good practice Multi agency dataset developed based on national minimum dataset and used by CPC to analyse data. Use improvement methodology and test of change to dig deeper into the data.

Priorities Year 3:

- The current strategy runs until 2023, Year 3 will see a new CP Strategy.

VIOLENCE AGAINST WOMEN AND GIRLS

Current Situation

The Violence Against Women and Girls Partnership (VAWP) is a multi-agency group set up to address domestic abuse and other forms of gendered violence.The partnership also encompasses a number of sub groups including: Training, Working with Men and Domestic Abuse towards Women with Learning Disabilities. An overarching objective is to meet the Equally Safe Standards in Argyll and Bute. The VAWP is represented on the National VAWP Forum.

Challenges

Covid-19 produced a number of challenges and saw domestic abuse cases increase whilst Court systems to address these were working at a reduced capacity and in a virtual manner. The VAWP moved from quarterly to fortnightly meetings to ensure closer inter-agency working and faster responses. Examples of this would include posters and media information put out to advice women of supports available. Also Women's Aid working closely with housing to provide accommodation for women fleeing from violence and members continued their services online.

Key third sector partners, such as Women's Aid and Rape Crisis, have been challenged by having to meet an increased demand for their services due to Covid-19, which has not been linked to a similar increase in resources.

An ongoing challenge for the work of the VAWP has been a shortage of resources and funds. This has restricted the delivery of identified training needs and service improvements.

The absence of a MARAC (Multi-agency Risk Assessment Conference) was seen as a challenge to achieving the objective of protecting women and girls. This has now been rectified and an effective process is in place.

How has Covid affected your past and future intentions and priorities?

Covid-19 prevented the VAWP meeting face to face but this has continued on a virtual basis. It also caused meetings to move from quarterly to every 2 weeks at its peak.This allowed for faster response to need and better interagency cooperation. Meetings continue to be virtual and now occur every 6 weeks.The pandemic does appear to have helped to develop closer working relationships; for example between Housing and Women's Aid.

Covid-19 has meant that more work delivered by key agencies has had to be done online and this continues. This has been proven to be beneficial to some service users and less so to others. This makes the need to increase digital accessibility across Argyll and Bute more important.

Covid-19 has also impacted on the work of key third sector partners with workloads increasing due to levels of trauma and domestic violence rising. This creates a pressure on their existing resources and this will be flagged to Council and other funding bodies.

Covid-19 has also demonstrated the need to deliver on the Equally Safe national Standards in Argyll and Bute and this will have resource implications for the VAWP. Whilst the monies from the DES Fund will go some way to meeting training needs that will improve services, other areas of work are not funded adequately. For example monies are needed if a communications plan is to be put in place and consultation and engagement occur more frequently with communities and lived experience groups.

VIOLENCE AGAINST WOMEN AND GIRLS

What have we done so far?

- The VAWP has developed its membership and now includes a wide range including; Police, Fire and Rescue, Colleges and Universities, Health, Social Care, Housing, Education, Adult and Child Protection and key third sector partners.
- The VAWP has contributed to the national agenda by its Chair attending the National Forum and the partnership taking part in relevant actions and consultations.
- Close working has taken place between member organisations during the pandemic to the benefit of women and children affected by domestic abuse. Monies were achieved via the Flexible Fund for Women's Aid and Rape Crisis, to assist this work.
- A VAWP led group is looking at the issue of domestic abuse and women and girls with learning difficulty and is currently identifying training and practice issues.
- The work of the MARAC continues to be developed and is enhancing the safety of those women at highest risk of domestic violence. A further roll out of training on the DASH model of assessment is planned.
- Training is planned to improve interventions with perpetrators by Justice Service Workers.
- Annual Returns are made by the VAWP to the Improvement Service.
- The VAWP Lead and Chair are working with the Community Justice Lead to ensure that the work of the partnership is properly integrated into the Argyll and Bute Community Justice Plan.
- The VAWP has supported and advised on the introduction of a Domestic Abuse Policy for Council employees and the introduction of a Domestic Abuse Pathway.
- The need for the introduction of the Safe and Together Model to Argyll and Bute services has been promoted to the Chief Executive, Head of the HSCP and Heads of Service and has been agreed as a key area of development. A bid was submitted to the Developing Equally Safe Fund to achieve this and this was successful; £68,582 was granted and will cover a Safe and Together initial roll out. It will also cover a wide range of other training including: Routine Enquiry, Awareness Raising, Working With Men and Harmful Traditional Practices. This will take place over a period of 2 years from mid October 2021. Also encompassed in this work will be a research project that will look at the effectiveness of these actions and the views of lived experience people, staff, managers and perpetrators.
- The 16 Days of Action were marked by a range of local actions including the lighting up of Statues and Buildings and a poster competition within schools.

What do we plan to do?

- A major area of work in the next 2 years will be the delivery of the Transforming Responses to Violence Against Women and Girls Project that is supported by the DES Fund bid monies. A Programme Board will be established to facilitate this. Use of the Domestic Abuse-Informed Practice and Systems: Self-Assessment Tool and Evaluation Framework at the start of the 2 year service transformation project will allow us to assess how services are currently working. This process will be repeated at the end of the 2 years and will allow for evaluation of change. The proposed research project by will add to this evaluation process and ensure the inclusion of lived experience voices.
- Develop our Data Base to more readily show the work of the partner agencies and emerging trends in domestic abuse and other gender based violence areas.
- Review the Equally Safe Plan for Argyll and Bute.
- Improve communications with lived experience and community groups and put in place a LBTQI Plan.
- Work to improve the services to women and girls with a learning disability who experience, or are at risk of experiencing, domestic abuse. This will focus on training for key teams and individuals and improving pathways.
- Work to improve how staff work with men in cases where there are domestic abuse and related child protection issues.

VIOLENCE AGAINST WOMEN AND GIRLS

Priorities Year 1

- Establish a Project Board to oversee the delivery of the Transforming Responses to Violence Against Women and Girls Project.
- Use the Domestic Abuse-Informed Practice and Systems: Self-Assessment Tool to establish a baseline for services prior to training and service change measures.
- Establish working groups to facilitate training and other aspects of the transformation project.
- Research to assess the impact of the Transforming Responses to Violence Against Women and Girls Project, to begin.
- Roll out of the Safe and Together Model to commence.
- Roll out of other training to commence including; Awareness Raising; Routine Enquiry; Zero Tolerance and Commercial Sexual Exploitation.
- Roll out of DASH training to relevant workers.
- Review the Argyll and Bute Equally Safe Plan.
- Development of Data Base that will assist us to monitor trends in Domestic Violence and other gendered violence.
- Deliver Annual Return from Argyll and Bute to the Improvement Service / National VAW Forum.

Priorities Year 2:

- Year 2 of the Transforming Responses to Violence Against Women and Girls Project to commence in October 2022.
- Roll out of the Safe and Together Model to continue and this to include 2 in-house Trainers to be trained.
- Research Project relating to the transformation project to continue.
- Other training areas to be delivered including: Awareness Raising; Routine Enquiry; Harmful Traditional Practices; The Impact of Domestic Violence on Children and Working with Men.
- Achieve improvement in services and pathways relating to women and girls with a Learning Disability experiencing or, at risk of experiencing domestic abuse.
- Review progress of the transformation project and the delivery of the Equally Safe Plan.
- Deliver Annual Return from Argyll and Bute to the Improvement Service / National VAW Forum.
- Have in place a Communications and engagement plan.

Priorities Year 3:

- Completion of the Transforming Responses to Violence Against Women and Girls Project. Project Board to carry out the Domestic Abuse-Informed Practice and Systems: Self-Assessment Tool and evaluate progress.
- Completion of the Research Project by Dr Anni Donaldson. This to be published and add to the evaluation process relating to the Transforming Responses to Violence Against Women and Girls Project.
- Consider the funding needs of the VAWP in relation to key work areas and develop and submit a further bid to the next round of the DES Fund.
- Review the Argyll and Bute Equally Safe Plan.
- Deliver Annual Return from Argyll and Bute to the Improvement Service / National VAW Forum.

ADULT PROTECTION

Current Situation

Last year the Partnership was subject to joint inspection of adult support and protection (ASP), one of 26 adult support and protection inspections to be completed between 2020 and 2023.

Such inspections aim to provide timely national assurance about individual local partnership areas' effective operations of ASP key processes, and leadership for ASP.

The inspection addressed 2 key Questions

- How good were the partnership's key processes for adult support and protection?
- How good was the partnership's strategic leadership for adult support and protection?

The findings from the Inspection focussed on a range of issues and now comprise an Improvement Plan. The areas include Chronologies, Risk Assessment and Protection Plans, Three Point Test and Capacity Assessment, Case Conferences and Reviews and timescales, Second Worker Guidance, Fire and Rescue inclusion and development, and further training and development.

Challenges

Covid: Operations have been challenged throughout the pandemic; such challenges have included home working, office closures, access to home visits, safety and a changed environment.

Staffing: Pressures on staff activity have been difficult and challenging. The Adult Protection Committee (APC) intends to explore this issue through development events later this year to consider how this might be alleviated.

Inspection: The inspection process was difficult for many of the above reasons particularly file reading arrangements, and demands made on professional and administrative staff during a school holiday period and Pandemic regulations.

Retirement of Lead Officer: The Lead Officer of some five years has retired and replacement is now complete. The authority has also seen major change in both senior management and locality management arrangements.

How has Covid affected your past and future intentions and priorities?

During the Covid-19 pandemic staff time and resources were particularly affected prompting the HSCP to think of new and innovative ways to protect the most vulnerable in our community from harm. In line with the national picture, Argyll and Bute HSCP are experiencing workforce challenges which have been exacerbated by the pandemic. Given the geography of Argyll and Bute, recruitment issues are greater in the more rural areas. However, teams strived to offer a consistent service across all localities.

Although we experienced challenges during the pandemic it strengthened the relationship between partner agencies and the HSCP. An example of this was that the Strategic Leadership Team formed the COVID-19 Caring for People Tactical Group which was made up of third sector agencies, the Community Planning Partnership, Argyll and Bute Council Customer Services, NHS Health Improvement Services and the Voluntary Sector. Collaborative working included weekly meetings with our partners who coordinated over 1,000 volunteers to support vulnerable adults. It also developed a communication strategy during the pandemic to encourage adults to use registered voluntary agencies when seeking support during shielding. The Lead Officer for ASP was an active member of this group and regularly reported on the CSWO in relation to Adult Protection activity. Links to the voluntary sector were enhanced throughout the period. The Committee has continued to meet and good information through newsletter and information support has been provided. Consideration as to how best to support our staff and communities will receive regular focus.

ADULT PROTECTION

What have we done so far?

- Provided a biannual Committee Development Session.
- Monitored impact of covid on adult protection issues.
- Produced a Monthly Newsletter on issues pertinent to ASP.
- Addressed financial harm, establishing an APC sub-group and ensuring regular information on the subject.
- Contributed to the Multi-agency Risk Assessment Conferences (MARAC) awareness training.
- Presented a Large Scale Investigation (LSI) Learning event.
- Ensured staff protected on investigations etc, and noted no real fall in referrals and activity.
- Provided training for Council Officers.
- Provided training on Defensible Decision Making.
- Presented a modern day slavery awareness event.
- Developed further awareness and understanding of Older People Abuse.
- Focused development of AP multi –agency awareness.

What do we plan to do?

- Ensure standardisation and improve quality of chronologies and risk assessment across the Partnership.
- Encourage in person participation in ASP case conferences where appropriate and safe to do so.
- Ensure appropriate use of trained second workers from Health and other disciplines.
- Ensure regular use of case studies and Significant Case Review (SCR) Findings.
- Explore further staff support and trauma aware practice.
- Improve knowledge and understanding of ASP process across the Partnership and raise awareness of this within the Community.

ADULT PROTECTION

Priorities Year 1

- Meet the Improvement Plan targets arising from Inspection.
- Implement Code of Practice changes.
- Implement guidance for Primary Care and GP's.
- Progress audit activity, case files.
- Develop issues arising from Initial Case Reviews, LSI findings.
- Develop 'escalation' policy.
- Support staff and communities as recovery from Covid regulation emerges.

Priorities Year 2:

- Develop improved data collection based on national dataset activity.
- Review SCR guidance and Code of Practice changes.
- Continue audit and review rolling programme.
- Develop protection links with Child Protection, Alcohol and Drug Partnership and Violence to Women.
- Continue staff support and contact programme.

Priorities Year 3:

- Monitor likely impact of national developments, mental health law review, national care service and other safety activity in trafficking etc.
- Develop enhanced service user/ citizen involvement in processes and policy.
- Continue process of review and audit.

COMMUNITY JUSTICE

Current Situation

Since the introduction of the Community Justice (Scotland) Act 2016 placed statutory duties on a range of partners to work together to reduce/prevent reoffending there have been significant shifts in direction for justice services. These shifts have been led by the national organisation Community Justice Scotland.

Community justice is a multi-agency improvement response to reducing/preventing reoffending, the complex needs of those involved in the justice system requires a wide range of services including: housing; addictions; mental health; employability and skills; and, third sector partners.

Argyll and Bute established a local Community Justice Partnership, chaired by the Chief Executive, membership includes all named statutory partners, Argyll & Bute Third sector Interface and Community Justice Scotland. The focus of the membership activity has been in relation to understanding our statutory duties and Justice Social Work developments, delays occurred due to the impact of the pandemic however the Justice Social Work Community Justice Delivery Plan will be finalised by March 2022.

Our community justice improvements focussed on Justice Social Work multi-agency planning because a significant range of the national improvements are delivered by them locally including:

- Community Sentences
- Diversion
- Bail Support
- Structured Deferred Sentences

The Argyll and Bute Community Justice Partnership will now take forward the development of a local Community Justice Outcome Improvement Plan and redefine our focus from April 2022.

There are a range of national drivers for the Argyll and Bute Community Justice Partnership to consider during 2022-2023, these include:

- Publication of the Scottish Government Vision for Justice (February 2022)
- Publication of a refreshed Scottish Government Community Justice Strategy and related Performance Framework (expected Spring 2022)
- Publication of a refreshed Scottish Government Equally Safe Delivery Plan (Violence Against Women and Girls)
- Reviewing the justice connections to support delivering The Promise
- Reviewing the Argyll & Bute approach and response to youth justice

Challenges

- The impact of the pandemic in relation to taking forward and implementing improvements
- The extensive range of partners and stakeholders involved in delivering improved community justice outcomes
- The extensive cross-cutting nature of effective community justice strategic planning across the wide range of partners
- The fast paced developments at a national level and how that translates into local improvement activity
- Resourcing improvements has been constricted by the current Scottish Government funding model
- Ongoing reviews of key national strategic documents

The Argyll and Bute Community Justice Partnership will consider these challenges during 2022-2023 when developing the next local Community Justice Outcome Improvement Plan

How has Covid affected your past and future intentions and priorities?

Prior to the pandemic a range of improvements and consultations were planned in relation to Justice Social Work, these halted during periods of restrictions, however Justice Social Work continued to provide their core service to people on community sentences and those being released from prison on statutory orders.

One key development during the pandemic was the finalisation of the Information Sharing Protocol between the Scottish Prison Service and Argyll and Bute Council, facilitating the transfer of information on what local citizens had entered prison and those due for release within 12 weeks. This has provided opportunity to develop our prison Custody to Community pathway in a more informed way with the ability to understand numbers and needs.

The Community Justice Partnership began meeting again in May 2021 and have taken the opportunity to review functions and delivery of statutory duties. Forward planning and implementation is now underway again.

COMMUNITY JUSTICE

What have we done so far?

- We have analysed the connections between Justice Social Work delivery and Community Justice developing a draft improvement plan for 2022-2024.
- Secured funding from the Corra Foundation to review our prison Custody to Community Pathway.
- Developed strategic links into the Alcohol & Drugs, Community Safety and Violence Against Women & Girls Partnerships.
- Contributed funding to a two year research project led by the Violence Against Women & Girls Partnership which will include understanding victims experiences with additionality to review the behaviours of men who perpetrate violence against women and girls.
- Developed strong partnership working with the national body Community Justice Scotland.
- Undertaking a review of the Community Justice Partnership to refresh our focus in light of the new national Justice Strategy and the pending Community Justice Strategy.

What do we plan to do?

- Support and monitor the implementation of the Justice Social Work Community Justice Improvement Plan.
- Finalise the Argyll & Bute prison Custody to Community Pathway and develop a monitoring process.
- Strengthen strategic links with other partnerships and develop new strategic links with Third Sector, Children's Services (Youth Justice), Employability, Welfare and other key partnerships.
- Support the Violence Against Women & Girls research project to learn from the experiences of women and improve our responses to men who perpetrate violence against women and girls.
- Continue to work with Community Justice Scotland, in particular, to respond to the publication of the new national Community Justice Strategy and Outcomes Performance and Improvement Framework (expected by June/September 2022 respectively).
- Produce a local Community Justice Outcome Improvement Plan and related performance framework.
- Embed an approach of continuous improvement in the functioning, delivery and outputs from our Community Justice Partnership.

COMMUNITY JUSTICE

Priorities Year 1

- Develop a local Community Justice Outcome Improvement Plan, in line with the priorities of the Scottish Government national Justice and Community Justice Strategies.
- Develop strategic and operational links with Third Sector and Children's Services (Youth Justice) and other key local partnerships.
- Support and monitor the implementation of the Justice Social Work (Community Justice) Improvement Plan.
- Review the learning from the first phase jointly commissioned research report for Violence Against Women & Girls and implement key recommendations.
- Implement the prison Custody to Community pathway, including performance reporting and monitoring.
- Finalise the review of our local Community Justice Partnership.

Priorities Year 2:

- Implement and monitor our local Community Justice Improvement Plan and performance framework.
- Support and monitor the implementation of the Justice Social Work (Community Justice) Improvement Plan.
- Review the learning from the second phase jointly commissioned research report for Violence Against Women & Girls and implement key recommendations.
- Carry out a validated self-evaluation of our Community Justice Partnership in line with the Care Inspectorate guidance.

Priorities Year 3:

- Implement and monitor our local Community Justice Improvement Plan and performance framework.
- Review the progress of the Justice Social Work (Community Justice) Improvement Plan, support future developments.
- Implement and monitor the improvements related to the jointly commissioned Violence Against Women & Girls research.
- Implement improvements to the Community Justice Partnership identified through the Care Inspectorate validated self-evaluation.

PUBLIC HEALTH

Current Situation

The role of the Public Health Team (PHT) in Argyll and Bute is to prevent health problems from arising and to enable people to lead healthy and active lives. The PHT works closely with the Public Health Department in Inverness. The PHT has an annual operational plan and publishes an annual report of activity. Key areas of work include:

- Health intelligence and data analysis, for example, regular epidemiology reporting
- Covid-19 pandemic response, for example, delivery of testing programmes
- Health improvement and community development, for example, leadership for the Living Well Strategy, suicide prevention and financial inclusion; plus delivery of national priorities for prevention including smoking and healthy weight
- Alcohol and Drug Partnership
- Health and care service improvement, for example, health screening, community engagement for service change and professional advice on equalities

Challenges

Managing the pandemic response and delivering existing portfolios has been challenging and has involved ongoing re-prioritisation of work since March 2020. Some topics were ceased as staff were redeployed, for example, NHS Highland Tobacco Strategy, supporting the Violence Against Woman Partnership and Equally Safe Strategy, and supporting the HSCP response to Adverse Childhood Experiences (ACEs). This situation remains uncertain and dynamic but there is hope for a shift back to core business from 2022 onwards.

A Covid-19 needs assessment carried out by PHT intelligence staff identified significant impacts arising from the pandemic, these include: mental health problems, employability, the economy and poverty. NHS Highland's Social Mitigation Plan endorsed by the board in May 2021 provides a framework to mitigate these impacts.

How has Covid affected your past and future intentions and priorities?

The following Health Improvement workstreams were not delivered due to Covid-19:

- Reduce tobacco related harm by delivering actions in the NHS Highland Tobacco Strategy
- Represent Public Health on Violence Against Women Partnership - VAW- Equally Safe Strategy
- Develop capacity in services and partners to develop a planned and effective approach to the ACEs agenda
- Workforce development and capacity building for PH activity, for example, Living Well self-management of long term health conditions, equalities, engagement

Ongoing PHT activity is delivered in a planned way and outlined in an annual operational plan. This plan is informed by: national PH priorities and new policy direction, NHS Highland objectives, HSPC priority areas, and community identified priorities.

Covid-19 and the resulting mitigation measures widened health inequalities for our most vulnerable. Going forward, more of our work will be focused on prevention and social determinants of health.

Staff have gained valuable skills, knowledge and experience in dealing with the pandemic which will be utilised as we move into a business-as-usual environment – we expect Public Health staff to be the last to transition back to 'normal'.

PUBLIC HEALTH

What have we done so far?

The PHT has a dedicated website **ablivingwell**

The annual report of activity for 2020-21 can be found in the Resources and Publications section.

- Delivery of Lateral Flow Testing and PCR testing programmes in the community in accordance with Scottish Government strategy.
- Daily and weekly detailed Covid-19 epidemiology reporting.
- Co-ordinating Caring for People community resilience response, including responding to 4,102 requests from the public and the delivery of 45,000 food parcels.
- Developing an emotional support helpline and thereafter commissioning third sector colleagues to engage with people in receipt of mental health services to evaluate how the pandemic had impacted them.
- The PHT conducted a scoping exercise by engaging with staff to complete a survey designed to identify gaps in knowledge around health screening (50 frontline Mental Health and Learning Disability staff and 19 Primary Care staff completed the survey).
- 73 successful smoking quits were recorded by the Stop Smoking Advisors using technology and innovative approaches to deliver their service.
- The PHT supported the implementation of the Scottish Government 'Every Life Matters' Strategy on Suicide Prevention, within the heightened economic and social pressures felt by individuals throughout the COVID-19 pandemic.
- The PHT collaborated on the development and implementation of an NHS Highland wide Social Mitigation Plan.
- Data and evidence to target effective interventions in response to Covid-19 was carried out by the Public Health Data Intelligence Specialists and reported within the Covid-19 Needs Assessment. Intelligence was gathered on direct health impacts of Covid-19, other health impacts, societal and economic impacts.
- In 2019 their key output was the Joint Strategy Needs Assessment.
- The PHT supported the completion of the Equalities Outcome Framework mainstreaming report to meet the Scottish Specific duties of the Equality Act and refreshed the Equalities Outcomes in partnership with Argyll and Bute Council and NHS Highland in summer 2021.
- HIV and other sexually transmitted infection support services continued to be delivered by Waverley Care with oversight and monitoring from the PHT.

What do we plan to do?

Public Health work is planned according to HSCP and board wide needs and well as national policy. An annual Public Health workplan is developed for Argyll and Bute, some of these actions roll forward each year set out in our priorities overleaf.

PUBLIC HEALTH

Priorities Year 1

- Develop joint Health Improvement plan between Argyll and Bute and north Highland.
- Pandemic recovery - Social Mitigation Strategy: child poverty; financial inclusion; children's rights; equalities; mental health improvement and support.
- Deliver on the 5-year implementation plan for Living Well strategy: workforce development; self-management; community link working; physical activity; mental wellbeing; suicide prevention; smoking cessation.
- Building capacity for health improvement: education; Living Well Networks; community planning; locality planning groups; engagement; place-based work.
- Respond and deliver national strategy and targets – suicide prevention; smoking cessation; Fairer Scotland.
- Alcohol and Drug Strategy actions – reduce drug deaths; recovery orientated support.

Priorities Year 2:

- Continuation of previous year's activity and new activity to be agreed in partnership.

Priorities Year 3:

- Continuation of previous year's activity and new activity to be agreed in partnership.

RIGHT CARE RIGHT TIME

Current Situation

Right Care Right Time

The above programme is a transformation area, previously known as Unscheduled Care. This means anyone attending or admitted to hospital that wasn't planned. Our ambition is to ensure we do provide the right care, in the right place at the right time.

The programme is currently looking at two key areas of improvement for patients;

- Enhancing community services to keep people at home, carry out increased assessment at home rather than in hospital and to increase re-ablement and independence to reduce dependency on care at home.

Minimising delay when in hospital with robust community pull back home, a streamlined and clear process for planning discharge and aiming to reduce the need for admission for some procedures, this can be known as Interface Care.

Links with Prevention Programme and Primary Care Modernisation is crucial.

What do we plan to do?

Scottish Government Winter Pressures funding is to address these key areas

Delayed Discharge

- Number of people delayed in their discharge from hospital
- Significant reductions in delayed discharge and occupied bed days
- No's to interim care, no's moved on from interim care and average length of stay

Staff

- Number of NHS staff recruited at bands 3 and 4, to roles across community services and acute

Assessment

- Increase in assessments carried out at home rather than hospital
- Evidence of a reduction in the number of people waiting for an assessment
- Evidence of a reduction in the length of time people are waiting for an assessment

Care at Home

- Numbers waiting for assessment of care
- Numbers waiting for care
- Unmet hours reduced

TEC/Equipment

- Increase in the use of community equipment and technology to enable care, or other digital resources to support care provision
- Evidence of resource to support the use of technology and digital resource

RIGHT CARE RIGHT TIME

Priorities Year 1

- USC leadership post in place
- Localities will have agreed actions plans to support the two key areas of improvement.
- Plan and progress spend on the recurring funding from Scottish Government.
- Established working groups with capacity to progress change and support localities
- Enhancing multi-disciplinary community teams to be responsive, flexible, highly skilled, continually assessing with a re abling and rehabilitation ethos and high quality end of life care with the skills to provide simple care that currently involves a hospital admission.
- Enhance clinical education for all staff , develop skill mix, apprenticeships and health care support worker skilled roles
- Provide enabling care at home that is effectively commissioned and planned for those who need it, with enough capacity to be provided following assessment at home and at the point of need.
- Performance metrics regular reported on.
- Evaluate spend on community teams, unpaid carer services & short breaks, response services, care at home, community palliative care and NHS GG&C delayed discharge.
- Consider models for community services with the aim of minimising different services/staff visiting people in community and improving flow through hospital.

Public engagement;

- What do our communities want to increase support unpaid carers?
- What do communities want from HSCP community teams?
- Agree model that assist us to move towards a National Care Service.

Priorities Year 2:

- Evaluate spend on community teams, unpaid carer services & short breaks, response services, care at home, community palliative care and NHS GG&C delayed discharge.
- Consider models for community services with the aim of minimising different services/staff visiting people in community and improving flow through hospital.

Public engagement;

- What do our communities want to increase support unpaid carers?
- What do communities want from HSCP community teams?
- Agree model that assist us to move towards a National Care Service

Priorities Year 3:

- Implementation stage

ADULT CARE-OLDER ADULTS/ ADULTS AND HOSPITALS

Current Situation

The overarching message from this strategic direction is to ensure older people are viewed as a valued asset with their voices being heard and when they require additional services they are supported to remain at home with as much independence as possible through multi -disciplinary and multi -agency working and that older adults can live in their own home or in a homely setting- home first. Implicit within this should be opportunities for prevention and well-being supports within communities which avoids the need for statutory service provision. Additionally clear access and pathways into services must be developed.

Challenges

This has been an extremely challenging year for older adult, adult services and hospital services across Scotland.

There has been an impact due to staff fatigue, staff having to isolate, loss of availability of staff from abroad and competition from other sectors of industry opening up again following lock down.

Hospitals have had to cope with the pandemic and Covid-19 patients, a presentation of more severe illness once restrictions lifted and staff fatigue and burn out. Infection control has had an impact on bed numbers, safe practice and the delivery of care.

Care homes have been working hard to maintain a safe environment for their residents, but many have had periods where admissions have been halted due to the need for caution and overall the occupancy figures have reduced. This reflects the national picture.

Day services have been closed since April 2020, reducing availability of support to unpaid carers.

Cares services have been met with recruitment difficulties and a diminishing workforce, with waiting lists for service being apparent.

Severe staff shortages have meant that services are currently being delivered through a range of different teams. There has however been an impact on hospital discharges and the delivery of re-ablement in the community. The level of service is also being reduced to only meet critical needs and the impact of this may affect other parts of the system including the impact on unpaid carers.

People with dementia have been particularly affected by the pandemic, with national evidence of the impact of isolation and disrupted routines.

Community alternatives to support statutory services are only just beginning to be taken forward.

How has Covid affected your past and future intentions and priorities?

The past year has posed many challenges for people and services across Argyll and Bute, with Covid-19 restrictions requiring service delivery to change and by reducing the social elements available to people in the community.

A range of services have lost significant numbers of staff, with recruitment remaining the key challenge to ensure services are able to deliver a safe and sustainable service going forward.

An Assurance Group has been meeting throughout the pandemic, with membership from a range of disciplines, Scottish Care and the Care Inspectorate. Any immediate risks in care at home services or care homes are raised at this meeting with appropriate advice guidance and support being actioned.

Additional funding through the Scottish Government under the umbrella of Unscheduled Care has been allocated to the partnership and priorities are being developed to ensure the opportunities for service redesign and ways of attracting and recruiting staff are established.

Funding is being targeted at processes to ensure flow of people through the system from community to hospital and out to community as quickly as possible.

A new way of delivering service to the front end of care at home has been commissioned with a mobile team being established in a number of areas. This type of service will be monitored to learn from what works well and how service changes could be instigated to ensure recruitment and retention of staff through changes to the commissioning process.

Additional support is also being delivered through dedicated nursing posts focusing on care homes.

We are working closely with the Scottish Government to develop a service for people with long covid.

ADULT CARE-OLDER ADULTS/ ADULTS AND HOSPITALS

What have we done so far?

- Diagnostic tests available for clinicians within clinical settings have been a growth area over the last decade. Technology has enabled a wide range of tests to become available, with variable degrees of sensitivity and reliability.
- Point of care testing (POCT) is defined as an analytical or physiological test performed at or near the site of patient care. In Argyll we rely heavily on POCT particularly in our community hospital Emergency Departments"
- Development of a robust assurance function for care homes and care at home service. This included the development of a Care Home Task Force a partnership with care homes and colleagues across the HSCP/NHS/Council.
- Increased and improved partnership working with external care providers.
- Establishment of an Older Adult Strategy Group to support and drive forward an Older Adult Strategy.
- Establishment of an Older Adult and Dementia Reference Group to ensure community engagement becomes part of the overall planning and development process.
- Re-establishment and redesign of day services providing a focus on critical respite for unpaid carers.
- Establishment of a Care at Home Strategy Group with a short term and longer term action plan taking account of immediate pressures and to plan for future development.Re-focus of the Care Homes and Housing work-stream to identify the need and direction of commissioning for the future.
- Appointment of an Unscheduled Care Lead to ensure all elements of hospital discharge and prevention of admission are standardised and integrated.
- Initial work is taking place to establish plans for the islands, taking account of the Island's Act and developing unique island solutions beginning with conversations on Coll, Mull and Tiree.
- Been part of the Place Based Review for Dunoon and Rothesay looking at how health and social care services fit with the wider place based approach.
- Implemented the Enhanced Community Dementia Team model in 3 localities within Argyll and Bute. Developed an operational framework for the service and recruited key posts to develop the Enhanced Service. This key service is still developing.
- Agreed proposals to permanently fund a 24 hour responder service with agreement that solutions are required for our island communities. The increased responder service will also respond to uninjured fallers within their homes and prevent unnecessary hospital admissions.

What do we plan to do?

- Over the next year we aim to introduce Colon Capsule Endoscopy (CCE) which is an additional supporting diagnostic test, which alongside optical colonoscopy is a highly accurate tool for investigating lower gastrointestinal (GI) disease. When a complete test is performed, CCE is no less effective than colonoscopy, and creates additional capacity to healthcare services with the aim of reducing waiting times for all lower GI diagnostics. In Argyll and Bute this will benefit patients by reducing patient travel to Oban for Endoscopy which can be really difficult especially after Bowel Prep.
- Over the next 2 years we aim to strengthen the strategy for governance and maximise the use of POCT across Argyll and Bute.
- Expansion of access to day treatments in our hospitals to reduce hospital admissions and use of inpatient beds.
- Our nursing workforce is being examined and establishment settings reviewed ensuring the right size, right skills workforce across all our hospital and community services.
- Support care at home through a challenging winter, linking unscheduled care elements to limit duplication and make best use of the total resource available.
- Extend the Community Hospitals into the community and provide a greater range of health related skills and services at home.
- Develop a community assets approach and identify a way in which people can be supported as much as possible within their own community before needing statutory services.
- Develop a care at home strategy to agree and monitor key developments to build a flexible and sustainable service.
- Develop a strategic and inclusive approach to Dementia within Argyll and Bute which sees supporting people with dementia in our communities as essential and part of everyone's role.
- Developing a meaningful conversation with islands around our health and care services.Develop a robust plan around winter planning, mapping out all elements of service delivery, what the pressures are and how they impact on each other.
- Encompass this within our commissioning strategy.
- Develop a sustainable staffing model at Lorn and the Isles Hospital linking in with the Acute Structure.
- Develop parts of our preventative model through use of Primary Care Link workers.
- To work in partnership with providers, supporting elements such as recruitment, training to ensure best use of resources.
- Review the use of Extended Community Care Teams and link them to other community services.
- Complete a building appraisal for internal care homes and develop an overarching care home and housing strategy. This will include the position of intermediate care within Argyll and Bute.
- Develop an Older Adult Strategy.

ADULT CARE-OLDER ADULTS/ ADULTS AND HOSPITALS

Priorities Year 1

- Support care at home through a challenging winter, linking unscheduled care elements to limit duplication and make best use of the total resource available.
- Develop a care at home strategy to agree and monitor key developments to build a flexible and sustainable service.
- Develop an Older Adult Strategy.
- Develop a robust plan around winter planning, mapping out all elements of service delivery, what the pressures are and how they impact on each other.
- Work in partnership with providers, supporting elements such as recruitment, training to ensure best use of resources.
- Review the use of Extended Community Care Teams and link them to other community services.
- Complete a building appraisal for internal care homes and develop an overarching care home and housing strategy. This will include the position of intermediate care within Argyll and Bute.
- Complete a needs assessment and collaborative health and social care plan for Coll, as a template for island approaches.

Priorities Year 2:

- Extend the Community Hospitals into the community and provide a greater range of health related skills and services at home.
- Develop a community assets approach and identify a way in which people can be supported as much as possible within their own community before needing statutory services.
- Developing a meaningful conversation with islands around our health and care services.
- Develop a sustainable staffing model at Lorn and the Isles Hospital linking in with the Acute Structure.
- Develop parts of our preventative model through use of Primary Care Link workers.

Priorities Year 3:

- Develop a strategic and inclusive approach to Dementia within Argyll and Bute which sees supporting people with dementia in our communities as essential and part of everyone's role.
- Encompass this within our commissioning strategy.

LEARNING DISABILITY SERVICES

Current Situation

There are approximately 377 Adults living with a learning disability and/or autism spectrum diagnosis known to Health and Social Care services within Argyll and Bute. Both nationally and locally we know the number of people with learning disabilities living into older age is increasing, with many presenting with a diverse range of complex and multiple interrelated health conditions.

This growing population with complex health needs brings about new challenges for health professionals and social care services. The planning and provision of quality health and social care is crucial to improving the health and quality of life of people with learning and/or autism across Argyll and Bute.

Providing effective support for people with learning disabilities and/or autism in ways that address their personal outcomes is a priority for the Argyll & Bute Health and Social Care Partnership (HSCP). Whenever possible, we will work to support people to live healthily and well within their local communities, with their families and friends. We will seek to enable people with learning disabilities to enjoy good physical and mental health, making use of facilities and activities available locally, in partnership with local groups and organisations from across the sectors.

Our shrinking population, recruitment and retention of health and social care staff and rurality of Argyll and Bute, presents many challenges to the delivery of learning disability and autism services.

Challenges

There are number of challenges that Argyll and Bute Health and Social Care Partnership's Learning Disability and autism services face:

- Recruitment and Retention issues across all Health and Social Care disciplines; T&C's, wages stagnated, limited career progression opportunities,
- Lack of appropriate housing models for service users, and affordable housing options to attract health and social care staff to the area.
- Limited autism specialist services and resources across A&B
- Limited employment opportunities and community assets for individuals with LD/ASD
- Increasing demand for services

How has Covid affected your past and future intentions and priorities?

The covid pandemic has had a significant impact on all health and social care services across Argyll and Bute. Much of the focus during the pandemic has been on crisis intervention and delivery of operational services to individuals with learning disabilities and/or autism.

As a result of national restrictions many of our support services were required to reduce capacity and limit face to face delivery of services. This has greatly impacted on the social isolation of many of the vulnerable people that we support.

As restrictions have lifted, services are now seeing the longer impacts of the covid pandemic and lockdown restrictions.There has notably been a deterioration in the mental health and wellbeing of many individuals as a result of a prolonged period of isolation. This creates additional challenges for relatively small operational teams and already stretched health and social care services.

LEARNING DISABILITY SERVICES

What have we done so far?

- Development of additional Core and Cluster models across A&B for Learning Disability services.
- Initiated the review and redesign of internal LD Day Services staffing structures across Argyll and Bute, to ensure equity and consistency across locations and ensuring they are fit for the future.
- Increased oversight and voice of LD & Autism services following the HSCP management restructure.
- Improved our communication and engagement with communities and service users, through the newly established HSCP Engagement Framework.
- Improved management of transitions cases through re-establishment of the Disability Transitions Group and better transition links with schools.

What do we plan to do?

- Review and redesign of LD Day Services across A&B, working in partnership with H&SC staff, care providers, service users, carers and wider communities to develop future models of support.
- Continue to utilise technology and telecare where appropriate to increase independence, whilst ensuring the safety and wellbeing of service users.
- Development of short, medium and long term housing strategy to ensure appropriate accommodation models for services users and affordable housing for H&SC staff.
- Further develop and improve communication and engagement with service users, carers, providers and H&SC to support the co-production of alternative models of care.

- Sustain and further improve on the positive feedback from external regulators regarding the quality of service provision (both internal and external).
- Further development of specialist Core and Cluster housing to support individuals with complex needs and reduce the requirement for individuals to be placed out with the area.
- Sustain and improve the positive and dynamic relationships with external providers and support services.
- Increase the uptake of Self Directed Support, through delivery of enhanced training to staff and development of easy read information for service users and/or carers.
- Reduce stigma in relation to learning disability and autism through delivery of joint training and/or awareness raising for staff across the HSCP.
- Implementation of the actions set out in the Learning/ Intellectual Disability and autism – Recovery and Transformation Plan.

LEARNING DISABILITY SERVICES

Priorities Year 1

- Development of A&B specific Learning Disability and Autism Strategies, in line with the A&B HSCP Engagement Framework.
- Review and redesign of LD Day Services across A&B, working in partnership with H&SC staff, care providers, service users, carers and wider communities to develop future models of support.
- Implementation of the actions set out in the Learning/Intellectual Disability and autism – Recovery and Transformation Plan.
- Continue to utilise technology and telecare where appropriate to increase independence, whilst ensuring the safety and wellbeing of service users.

Priorities Year 2:

- Increase the uptake of Self Directed Support, through delivery of enhanced training to staff and development of easy read information for service users and/or carers.
- Development of short, medium and long term housing strategy to ensure appropriate accommodation models for services users and affordable housing for H&SC staff.
- Sustain and further improve on the positive feedback from external regulators regarding the quality of service provision (both internal and external).
- Reduce stigma in relation to learning disability and autism through delivery of joint training and/or awareness raising for staff across the HSCP.

Priorities Year 3:

- Further development of specialist Core and Cluster housing to support individuals with complex needs and reduce the requirement for individuals to be placed out with the area.

MENTAL HEALTH SERVICES

Current Situation

There are increasing numbers of people living with mental health problems in our communities and an increasing demand for support and care services centred on all areas of mental health. Specifically,

- in-patient beds for people with severe and acute episodes of mental ill health
- Community services to support people living at home.

It is well recognised that anticipatory and crisis care planning reduces admission to a hospital bed and a positive therapeutic environment supports recovery. A multi-disciplinary team approach provides more efficient and effective care in the community and new technologies can support care delivery.

Recruitment to specialist mental health professionals and care support workers remains challenging.

Challenges

- Increasing demand for services.
- Recruitment to specialist mental health professionals.
- Recruitment to care/support workers.
- Delivery of care in a large wide spread geographical area.
- Ability to provide a response to acute episodes of care out with normal working hours.

How has Covid affected your past and future intentions and priorities?

We have continued to work towards our priorities; however during Covid many barriers to change were lifted which accelerated our implementation, such as Near Me platform. This promoted our ability to deliver interventions remotely and reduced travel requirements for our staff, increasing the capacity of our teams depending on previous travel requirement, This has prompted us to think about how we retain this and although not suitable for all or that all our patients like this delivery model, will assist us to deliver more interventions.

Many of our groups and face to face delivery of services ceased unless clinically determined required, this has impacted on social isolation and understanding the nuances such as body language, environment and carer input that is important in seeing the whole picture in mental health support.

The Scottish Government have been giving much focus on MH and Addictions services since Covid and the full extent of Covid on our populations mental health is yet to be fully understood. Mental health referral rates were increasing prior to Covid and teams struggled to meet pre-Covid demand for services, however through remobilisation and renewal, the Scottish Government have directed our priorities going forward. To date this has a focus on child mental health, psychological therapies, eating disorder pathway, perinatal mental health and primary mental health care and we will continue to work alongside our colleagues to remobilise in line with the directives and priorities highlighted.

MENTAL HEALTH SERVICES

What have we done so far?

- Completed a review of our Community Mental Health Teams recommendations of which (still subject to approval) will be actioned via our Mental Health and Dementia Steering group.
- Identified resource to deliver the Wellness Recovery Action Planning (WRAP) approach to enable people to self-manage their mental wellbeing.
- A dedicated mental health/addiction housing practitioner post, fully funded by housing, will continue to provide support and linkages between housing and support services.
- Recent Islay trial of 'Near Me' the use of video consultation to support primary care mental health workers and clients.
- Agreed a new locality based consultant model of care.
- Establishment of inpatient beds within Mid Argyll Community Hospital (July 2018).

What do we plan to do?

- Continue to support the statutory requirement of Mental Health Officer duties within services.
- Ensure consistency of agreed method of engagement with service users, carers and other relevant representatives.
- Refine and implement local Mental Health Strategies.
- Implement the locality based consultant model of care and work to resolve recruitment difficulties. This has been completed in 2021, each locality now has an adult general consultant attached to the community team. There is also a new Addictions consultant's.
- Continue to explore new technological ways of delivering therapy and support. We have a digital footprint of cCBT, Silverlight platform and digital CBT all available in A&B. During Covid the use of and roll out of Near Me digital secure platform was accelerated to allow us to provide therapy and support to our patients throughout the pandemic.
- Further develop the review and implementation of Community Mental Health Teams across Argyll and Bute. Teams are being streamlined where psychological therapies are becoming aligned to the newly recruited Consultant Psychologist, Primary care teams are embedding alongside GP surgeries, MHOs and MH SW are managed as an A&B wide service and Crisis teams are established in localities.
- Increase crisis interventions in the community to reduce risk and to manage hospital admissions safely, if required. In the last year of development, all localities have access to urgent and emergency practitioners, they work between the hours of 10am to 8pm 7 days per week and will undertake all mental health crisis assessments, can provide increased support for up to 14 days, refer on to third sector or statutory services or arrange and escort patient to hospital if required.
- Work with Primary Care colleagues to help support the roll out of anticipatory and preventative care strategies associated with the new GP contract. Primary care team as detailed above have been established in each locality, they are working toward piloting self-referral pathways to maximise timely assistance and help.

MENTAL HEALTH SERVICES

Priorities Year 1

- Progress planned developments associated with Transforming Together agenda for mental health.
- Community Mental Health Services review and outcomes.
- Psychological Therapies – we are working with the Scottish government to develop a business case to enhance and develop our PT services across A&B and to assist us to meet the expectations and demand for services in a timely and effective manner. The teams are now realigning to make an A&B wide service under one management structure to ensure better oversight of waitlist and service delivery at tier 3 and 4.
- The primary care mental health team have also realigned to work across GP surgeries and to support those presenting with mild and moderate mental health concerns. This team have a MDT approach and have a wellbeing nurse, OT, guided self-help worker and primary mental health worker in each locality.
- Care Reviews.
- Inpatient services – addition of a consultant psychiatrist for the inpatient unit 3 days per week. Recruitment of RMNs remains fragile due to the national shortage and the inpatient environment holds large vacancies, support around recruitment and retention is well under way across NHS Highland.

Priorities Year 2:

- Establish clear pathways to keep patients in local hospitals before transferring to acute units and further developcommunity supports and strategies, aimed at supporting individuals to remain at home and in their community and ensure effective admission and discharge planning.
- Urgent and emergency teams embedded in OLI, MAKI and C&B for all MH crisis presentations and support between the hours of 10am to 8 pm 7 days per week using Action 15 monies. The team also provide an escort support for those who need to progress to hospital under MH (Scotland) Act 2003.

Priorities Year 3:

- Consider and consolidate standardisation of processes; roles and responsibilities; care and support co-ordination and utilisation of effective training and delivery models (i.e. specialist / generic), as appropriate to support mental health and dementia services locally.
- Further scoping of leadership and management of teams have enabled operations managers across the service, to ensure less variation and to support standardisation of process and to reduce barriers to pathways, this will continue once remobilisation of services progress.

PRIMARY CARE (GENERAL PRACTICE)

Current Situation

There are 31 GP practices in Argyll and Bute, with a registered patient population of 89,154 as at 1 July 2021 .

The new GP Contract was introduced in April 2018 requiring service redesign delivered by a wider multi-disciplinary team. The national priority is to reduce the workload of GPs and practices by the HSCP delivering services.

These services will be delivered by clinicians such as Pharmacists, Physiotherapists and Nurses

There are 6 main streams to this work, with the national priority for the first 3, with a target date ofApril 2022.

- Vaccination Transformation Programme
- Pharmacotherapy Services
- Community Treatment and Care Services
- Urgent Care (Advanced Practitioners)
- Additional Professional Roles
- Community Link Workers

This will see extra funding of £2.9 Million per year.

The past year has also seen the delivery of the COVID vaccination campaign by HSCP teams. While not part of the 2018 GMS contract, this comprises an important part of the vaccination workstream. At April 2022, COVID vaccinations, some childhood immunisations and some CTAC services are being delivered by HSCP teams. Pharmacotherapy, Physiotherapy, Mental Health and Community Link Worker services are in place covering the majority of the population of A&B.

It is recognised that there are challenges in implementing the new GP contract in Argyll and Bute within a remote rural and island context, and an options appraisal has been approved by Scottish Government enabling us to explore rural flexibility.

General practice has remained open throughout the pandemic within a safe physical environment. New innovative ways of working to support patients to access care, for example, the introduction of telephone triage and the use of remote consulting (Near Me) has changed the way patients access care while social distancing and other infection control measures are required.

The recruitment of a head of primary care in October 2021 brings new opportunities to develop the support infrastructure for general practice in Argyll and Bute.

Challenges

- The provision of Out of Hours primary medical services in our isolated and remote island communities
- The ageing workforce and increasing vacancies in our GP practices. When considered alongside the need to provide GP OOHs, means it is more difficult to recruit GPs
- Developing new service models and recruiting other clinical staff to allow the transfer of work from GP practices to HSCP staff
- Insufficient levels of funding available under the primary care modernisation agenda to deliver all aspects of service redesign as set out by the 2018 GMS Contract
- Delays in delivering the services outlined in the 2018 GMS contract
- Delivering the extended flu and Covid vaccination campaigns
- Using technology to offer support and provide a service to staff and patients
- Provision of robust fit for purpose IT systems required for the delivery of modern GP Services
- Sourcing adequate fit for purpose accommodation across A&B for new MDT ways of working
- Encouraging recruitment to GP and new MDT posts within A&B
- Developing clinical leadership and developing structured links between general practice and the HSCP

How has Covid affected your past and future intentions and priorities?

- All GP Practices remained open during Covid pandemic. GP Practice contingency plans and local buddying arrangements between GP practices established.
- New innovative ways of working to support patients to access care while social distancing and other infection control measures are required
- Telephone triage, Near Me and Asynchronous Consulting
- Telephone triage of all contacts – majority of contacts resolved without face to face appointments where clinically appropriate
- Face to face appointments more appropriately directed across the primary healthcare team
- Investment in hardware to support remote working and consulting carried out by all disciplines (GP, ANP, PN, Pharmacists, Physiotherapists, etc)
- Development of safe physical environments, red room pathways, social distancing
- Uncertainty remains around the future of the COVID and flow navigation pathways
- Community Pharmacies have provided patients with access to their medication during the pandemic, including extending deliveries to shielding patients. The pharmacies have also been providing advice on minor ailments, medicines use and with extension of pharmacy first free access to treatment for uncomplicated Urinary Tract Infection in women and Impetigo.The pharmacy team have supported medicines use such as oxygen in hosptials & Red Rooms as well as supporting the planning for the covid vaccination programme along with supply

PRIMARY CARE (GENERAL PRACTICE)

What have we done so far?

- Developed a Primary Care Modernisation Programme Board reporting to the IJB.
- Pharmacotherapy teams are in place to provide a new medicines management service within most GP practices in each locality. Teams comprise of pharmacists and pharmacy technicians.
- A plan for a primary care nursing team with posts located either in community hospitals or in GP practices has been agreed in consultation with individual GP practices to support community treatment and care and vaccination transformation within existing primary care modernisation funding.
- Agrees and partly appointed to an HSCP primary care nurse management structure to oversee the transformed delivery of vaccinations, community treatment and care and some aspects of urgent care within Argyll and Bute.
- First Contact Practitioner Musculoskeletal Physiotherapists are in post are providing a service to some practices in each locality. Where the service is in place, patients benefit from quicker access and treatment, reducing unnecessary referrals to GPs.
- A fixed term first contact practitioner post has been recruited to with the specific purpose of extending the reach of the existing primary care musculoskeletal service to remote and island GP practices through more effective use of technology opportunities.
- To help address specific recruitment challenges to the pharmacotherapy service a remote hub model has beencreated in Helensburgh. The hub run by Pharmacy technicians & Assistants with pharmacist oversight will provide a minimum consistent level of service to all practices.
- A Primary Care Mental Health Service is now operational for some GP practices in all localities providing time limited intervention for patients with common mental health problems. There is a monthly average of 90 patients now referred to this service.
- Facilitated closer working between GP practices across Argyll and Bute including Lochgilphead and Inveraray, Helensburgh and Garelochhead and the 3 Islay practices.
- Merged the GP Practices on the Isles of Mull and Iona and recruited GPs to the new Mull and Iona Medical Group under an independent General Medical Services Contract.
- Undertaking a review of the strategic plan for the provision of primary medical services for the patients of Kintyre Medical Group.
- Creation and implementation of 3 Whole Time Equivalent (WTE) Advanced Practice Anticipatory/ Emergency Care Nurses working in partnership across 5 GP Practices within Helensburgh and Lomond Locality.
- Developed a network of GP Cluster Quality Leads in each locality, supporting organisational priorities.
- Developed a network of Clinical Lead GPs across Argyll and Bute.
- Investment in General Practice to enable the use of telephone triage and remote consulting.

- Investment in General Practice to improve telephony.
- Established locality wide GP Out of Hours (OOHs) services in all mainland areas, centred on the local hospital. Continued to support the single island service on Islay.
- A 3 year contract to commission a Community Link Worker service for 10 GP practices in Argyll and Bute has been awarded to We are With You (formerly Addaction). The service will take referrals from primary care teams and use a person-centred social prescribing approach to strengthen the link between primary care, other health services, and community resources.

What do we plan to do?

- Complete the development of a combined CTAC and vaccination service covering all practices in A&B. With flexibilities for rural practices.
- Develop a highland-wide travel vaccination service.
- Extend a self referral option for primary care mental health services to additional GP practices. This is being successfully piloted in 1 GP practice in each locality.
- Produce a primary care mental health plan in collaboration with Mental Health.

PRIMARY CARE (GENERAL PRACTICE)

Priorities Year 1

- Establish immunisation teams to administer vaccines in all localities and assess recruitment priorities based on the impact on workload of delivering Covid vaccines and the additional flu vaccine cohorts.
- Develop an HSCP model for travel health and travel vaccinations.
- Recruit to primary care nursing posts as agreed in the Primary Care Modernisation Implementation Plan to support community treatment and care and some aspects of urgent care.
- Implement transitional arrangements where practices continue to provide some services.
- Provide information of what services will not transfer from GP practices as an outcome of the rural options appraisal process. The Scottish Government and SGPC will negotiate a separate arrangement including funding for these practices who will continue to provide services after 1 April 2022.
- Contribute to review of sustainable services on the island of Coll.

Priorities Year 2 and 3:

- Ensure that locality based vaccination teams and campaign planning are sufficiently robust to deliver Vaccination & Immunisations and Childhood Vaccination in line with their removal from GP practices from 1 April 2022.
- Identify any ongoing practice involvement in delivery of vaccinations beyond 1 April 2022 under the terms of the transitionary service arrangements (including additional payment arrangements).
- Assess the impact on GP practices following the service redesign of Pharmacotherapy using a remote hub model.
- Delivery of a strategy for island health and social care provision specifically for out of hours and urgent care.
- Agree, finalise and deliver a midwifery model for pertussis delivery across Argyll and Bute.
- Establish a sustainable GP out of hours service for Jura, linking it with Islay and building community resilience.

DENTISTRY SERVICES

Current Situation

Challenging recovery from the pandemic, with General (High Street) dentistry having reduced capacity significantly, including a long period of low volume due to enhanced infection control measures. Large backlog of universal dentistry, with impacts on the capacity to see targeted groups. Historic provision to island locations was stepped down during the pandemic and has yet to recommence.

Challenges

Lack of clarity around the extent to which general dentistry will recover back to previous NHS provision (and therefore the focus of Public Dental Services). Potential for PDS to require expanding to provide a universal service rather than focussing on targeted groups.

Retirements' relating to orthodontistry has created a gap within Argyll and Bute.

Operational challenges ongoing relating to a large and dispersed geography with small PDS teams.

DENTISTRY SERVICES

What have we done so far?

- New PDS business manager with clear agenda around improving quality and greater standardisation across all A&B dental sites.
- Remobilisation ongoing, taking into account of new infection control measures

What do we plan to do?

- Renewed focus on priority groups.
- Deliver a plan for island visiting services.
- Continue to monitor GDS (High Street Dental) activity and expand PDS if required to meet general need.

DENTISTRY SERVICES

Priorities Year 1

- Renewed focus on priority groups.
- Deliver a plan for island visiting services.
- Continue to monitor GDS (High Street Dental) activity and expand PDS if required to meet general need.

Priorities Year 2:

- Dentistry Services- Dependent on GDS recovery from pandemic

ALCOHOL AND DRUG PARTNERSHIP

Current Situation

The Argyll and Bute Alcohol and Drug Partnership (ADP) is a partnership of statutory and voluntary organisations working together to achieve a reduction in the harmful effects of alcohol and drugs on both individuals and the wider community. Alcohol and drug support is available in all localities throughout Argyll and Bute provided by our integrated Argyll and Bute Addiction Team (ABAT) and by We Are With You, an external provider of community based adult substance use recovery services. Our delivery goals and strategy are led by the Scottish Government Rights, Respect and Recovery **(https://www.gov.scot/publications/rights-respect-recovery/documents)** and the National Drugs Mission fund **(https://www.gov.scot/publications/national-drugs-mission-funds-guidance)**

VISION

Argyll and Bute is an area where "we live long, healthy and active lives regardless of where we come from" and where individuals, families and communities:

- have the right to health and a life free from the harms of alcohol and drugs
- are treated with dignity and respect
- are fully supported within communities to find their own type of recovery

PREVENTION AND EARLY INTERVENTIONS	DEVELOPING RECOVERY ORIENTED SYSTEMS OF CARE	GETTING IT RIGHT FOR EVERYBODY	PUBLIC HEALTH APPROACH TO JUSTICE.
OUTCOME: Fewer people develop problems with alcohol and drug use	**OUTCOME:** People access and benefit from effective, integrated, person-centred support to chieve theirr recovery	**OUTCOME:** People affected by alcohol and drugs use will be safe, healhy, included and supported	**OUTCOME:** Vulnerable people are diverted from the justice system wherever possiible, and those within justice settings are fully supported

Challenges

Partnership working is often challenging. Each partner in the ADP, although working towards common goals, have different structures, cultures, aims, values and data sharing protocols. Some may be working within different legislative frameworks which define their powers, their duties to provide specific services and the targets and outcomes that they are expected to meet.

How has Covid affected your past and future intentions and priorities?

- Some services have not been developed further due to Covid; however a service has been in place.
- Alcohol Brief Interventions have been on hold?
- We would hope to increase the outreach that has been made necessary because of Covid, enabling people to access services without having to travel to a location.
- Some partners have disengaged due to Covid pressures and we will aim to rebuild and strengthen the partnership.

ALCOHOL AND DRUG PARTNERSHIP

What have we done so far?

- The ADP governance structure has greatly improved but our aim is to continually improve and strengthen the partnership, maintaining input from people with lived and living experience.
- Recovery communities expanded their membership. The communities are primarily led by people with lived experience and all have people with lived experience involved in the programming and organisation of the regular activities.
- Funding has been provided to extend the Scottish Government counsellors in secondary schools program to children in primary 6 & 7.
- Links have been strengthened through the creation of a Recovery Steering Group which aims to represent all of the Recovery Communities and develop a collective voice on their behalf.
- Both ABAT and WAWY have staff trained to distribute Naloxone to individuals & their family members. Both teams also provide Injecting Equipment Provision (IEP) utilising outreach and click & collect approaches.
- The existing school-based support service has continued, though the service has had to adapt due to Covid-19 restriction, with access to the schools limited in many cases. Services have been innovative in their use of social media, instant messaging, text, phone video-conferencing and meeting outside of school grounds.
- The ADP has recently received the results of a needs assessment to inform the development of services for children and young people in Argyll & Bute.
- Family Support groups have been setup in Helensburgh, Cowal, Bute and Oban.
- We Are With You have developed new ways to reach individuals and families who need support using telephone and video appointments.
- The Custody to Community Pathways for people leaving Prison and returning to Argyll & Bute is aimed at ensuring all are provided with Naloxone on liberation.
- We are working with Planet Youth and partners in Education on the Icelandic Prevention Model pilot.
- A dedicated mental health/ addiction housing practitioner post, fully funded by housing, will continue to provide support and linkages between housing and support services.

- We have initiated Scotland's first peer led Recovery Advocacy programme. This has been developed by a partnership of Scottish Recovery Consortium, Lomond & Argyll Advocacy Service and REACH Advocacy.
- Where appropriate prison addiction staff contact ABAT to continue clinical treatment in the community. This approach has worked well for the continuation of prescribed methadone and buprenorphine.
- A Substance Misuse Liaison Service has improved access to treatment. Pathways have been developed within A&E departments. This has worked in tandem with the new Emergency and Urgent Mental Health. Access to the weekly The Non-Fatal Overdose (NFOD) report allows follow up with individuals who are either not known to service or not currently on caseload.
- The ADP has supported the S3 Drama 2021/22 programme, both financially and by attending a number of the events, for several years. The yearly programme is a partnership approach between Health and Education where a drama production, pupil workshop, three lessons plans, a Q&A with service providers and a pupil resource booklet are provided for each S3 pupil. In the last three years this has been part of a roadshow delivered around October.Due to the pandemic the initiative was scaled back to include a live online drama production facilitated by classroom teachers and delivered in March 2021 followed by three lesson plans. The drama production covers a wide range of issues including alcohol use, sexual exploitation, sexuality, mental wellbeing, self harm and other key issues.Previous evaluations have consistently demonstrated that pupils are better informed of services and have found the medium of drama particularly effective.
- Cool2Talk is a web based question and answer service aimed at 12 – 25 year olds. The service answer questions posted on a website within 24 hours. The questions received are varied and cover topics such as emotional and physical health, alcohol and drugs, sexuality and many others. The most commonly asked questions focus on emotional health and dealing with stress. The ADP has been the main funder of this service for a number of years. Although there are only a few questions which are specifically related to the use of alcohol or drugs the service is seen as an opportunity for early intervention and prevention rather than as a specific support for alcohol and drug issues. Online chat sessions with trained counsellors take place two to three times a week; these offer real time support on any issue.
- WAWY introduced online Mutual Aid Partnership (MAP) group sessions three times per week. They also offered safe distanced walk & talk sessions with people who are unable to engage by phone/digital. Where required they carried out doorstep welfare checks when they were unable to make remote contact with people.

What do we plan to do?

- We aim to continue to work in partnership to deliver the ADP strategy.
- We will work in partnership to deliver the Medically Assisted Treatment Standards and the objectives of the national mission.
- We will develop a ROSC web based system and app to make this more accessible.
- We will work with partners to deliver a Cowal hub that offers a one stop shop to support services including, advocacy, GP practice staff, drug and alcohol treatment services, etc. If successful we plan to develop hubs in other localities.
- We will assess the needs analysis and move forward with a revised approach to support for children and young people affected by their own or another's substance use.

ALCOHOL AND DRUG PARTNERSHIP

Priorities Year 1

- The ADP strategy.
- Initiate MAT standards.
- Increase access to residential rehab.
- Develop a revised approach for children and young people's support.
- Initiate the whole family approach strategy.
- Increase access to advocacy.
- Work with criminal justice to create a continuation of care.
- Shared care.

Priorities Year 2:

- The ADP strategy.
- Develop community hubs throughout Argyll and Bute.
- Expand on the whole families approach.
- Continue to deliver to the requirements of the national mission.
- Implement the revised approach to children and families.

Priorities Year 3:

- Create a new strategy.
- Continue to work in partnership to expand on what is working and developing what is not.
- Continue to deliver to the requirements of the national mission.

ALLIED HEALTH PROFESSIONALS

Current Situation

Professions within A&B are Physiotherapy, Occupational Therapy, Podiatry, Speech & Language Therapy, Radiography, Orthotics, Audiology and Dietetics. These services offer a diverse range of therapeutic diagnostics and interventions with the overall aim of minimising symptoms, supporting condition and self-management. Diagnosing and treatment of conditions from cradle to grave to enable full engagement in daily life and occupations, increasing independence and rehabilitation and reablement following injury, illness or disease.

AHP's work in all areas including adults, children and young people, mental health, dementia, learning disabilities. The services have teams in each locality and have staff on or visit islands regularly working in hospitals, community, schools and primary care amongst other setting.

The AHP professions are currently highly valued for their impact on delivery of strategic aims to help people remain happy, healthy and independent. The clinicians work on treatment or goal plans collaboratively with patients to help reach optimum level of function.

AHP's in NHS Highland are currently one of the most advances across NHS Boards in establishment setting which is a process to meet the statutory obligations of the health & Care Staffing Act (2018) Scotland. This puts a duty on board to ensure safe staffing levels. We are currently in Cycle 2 of this process. (see priority 1)

Challenges

Remobilisation – increased time for cleaning, ability to only visit one school per day, reductions in face to face appointments and build up of waiting lists during the pandemic have left a legacy of catch up with active caseloads and people waiting to be seen. Every effort and short-term funding is being used to assist.(Priority 2)

Recruitment-we struggle to recruit to certain professions (OT, Physio and Radiography currently), particularly across the west of Argyll. Time taken to replace vacant posts leaves gaps in service and reliance on locums.(Priority 4)

Fragility of teams, most of our teams are small and cover a wide range of clinical services. Issues with recruitment and retention, or any staffing gaps have a big impact on service provision.

Financial challenges mean that there is constant pressure around savings and minimising of spend on provision of equipment, additional staffing and training. Some clinical areas have minimal AHP staffing or no staffing e.g. Mental health physio.

How has Covid affected your past and future

Increased focus on fragility and capacity of teams. Noted difficulty is visibility of AHP activity and gaps in service. (we have 68 professional services across localities of A&B)

Increased remote working in clinical and non-clinical work. Increase in efficiency and reduction in travel.

Increased waiting times for services (Priority 2)

Increased and advanced levels of frailty and deconditioning seen in our population-trying to increase our offer around physical activity with collaborative working with leisure services and third sector.

ALLIED HEALTH PROFESSIONALS

What have we done so far?

- AHP leaders and the teams work above and beyond to provide high quality clinical care despite challenges.
- AHP's view themselves as having a role in prevention and early intervention and are striving to increase their input earlier in patient's lives to either prevent or minimise impact of illness, disability or injury.
- AHP's are core members of the multi-disciplinary team and have enhanced MDT working significantly into primary care in the last three years.
- AHP's are currently one of the first within NHS Scotland boards to develop and carry out establishment setting.
- Increased our rehabilition skills in all areas to support major trauma, long-term conditions and neurological conditions and diseases.
- Recruitment of a Housing OT to support assessments for adaptations to individual housing.

What do we plan to do?

- Ensure appropriate staffing levels within all AHP Services.
- Remobilisation.
- Embed OT and Physiotherapy into primary care as part of primary care modernisation.
- Increase capacity of AHP professions to deliver preventative and early intervention, progress to prehab and preablement as well as rehab and reablement.
- Improve retention of staff and make Argyll & Bute an employer of choice for AHP's.

ALLIED HEALTH PROFESSIONALS

Priorities Year 1

- Continue to develop standard tools and process for establishment setting ready for cycle three. Agree establishments for A&B teams.
- Develop a dashboard for visible demand and activity data for AHP teams.
- Scope offer of first contact physiotherapy to remote and rural practices.
- All AHP staff to do Health Behaviour Change training and review the professions offer to prevention.
- Review of recruitment within AHP professions and enhance skill set opportunities g. Increase number of advanced practice roles, therapy assistant support to qualify as an AHP.

Priorities Year 2:

- Agree service specifications for all AHP Services and roll-out Job planning within teams.
- Address long waits-all over 52 weeks become priority 1. Establish rigorous triage in all AHP teams.
- Aim to have all practices offering First Contact physio.
- Build in capacity for universal and targeted intervention with groups e.g. Aging adults, nursery children – whole population approaches to healthy living.
- Delivery of actions e.g. Guest lecturing, increase in student placement offers, progress of therapy apprenticeships.

Priorities Year 3:

- Have established yearly cycle tools and process.
- Ensure all national and local waiting times targets are met.
- Primary Care-increase of first contact to other professions.
- Measure outcomes of preventative and targeted work alongside specialist 1-1 and reactive work.

CARERS

Current Situation

Argyll and Bute Health and Social Care Partnership (A&BHSCP), and their partners, including the Carers' Partnership, believes that caring for others, at an individual, family and community level is the most important work that any of us can do.

Our vision is that all Carers both young and adult: Feel supported, valued, informed, respected and engaged in their role as a Carer - Are able to have a life alongside caring

Our Values Working with Carers

Our values reflect the values of A&BHSCP. These include compassion, integrity, respect, continuous learning, leadership and excellence **(CIRCLE)**.

We will work with Carers in ways that are:

Person centred

People with a caring role should be aware of any support/ services available so they can make informed decisions about them. They can choose what, if any services they wish to be involved in or even if they wish to make it known that they are a carer. Each person with a caring role is unique and this should be recognised and respected regardless of their circumstances.

Integrity-based

People with a caring role should be asked for feedback about how they perceive and experience services. This information should be considered and, where appropriate, acted on and used to rectify mistakes and improve service provision and design. Any outcomes of such feedback should, in turn, be fed back to those appropriate people

Caring and Enabling

Carers are assisted and supported to minimise the negative impact of their caring role while maximising their confidence to cope with their caring role and thrive within that and other areas of their daily life.

Compassionate

People with a caring role are treated with positive regard and empathy at all times

Respectful

People with a caring role are respected at all times; their knowledge and skills are recognised and valued.

Carer support services are available across Argyll and Bute, with 4 administrative areas covering: Helensburgh and Lomond,- Bute and Cowal, Mid Argyll, Kintyre and Islay & - Oban, Lorn and Isles

Support is available to ensure all carers can access advice and support no matter of their age or caring role.

Adult Carer Support Plans and Young Carer Statements will help support carers in obtaining the right level of support for them. Short break and the local eligibility criteria all help to carer outcomes.

In order to address the requirements of the Carers (Scotland) Act 2016, the following five outcomes were identified and are incorporated into Argyll and Bute's Carers Act Strategy

1. All Carers are identified at the earliest opportunity and offered support to assist them in their caring role
2. Young Carers are supported with their Caring roles and enabled to be children and young people first
3. Mental and physical health of Carers is promoted by ensuring that they can access or be signposted to appropriate advice, support and services to enable them to enjoy a life outside their caring role
4. Carers have access to information and advice about their rights and entitlements to ensure they are free from disadvantage or discrimination in relation to their caring role

People who provide care are supported to look after their own health and wellbeing which includes reducing any negative impact of their caring role on their own health and wellbeing.

Challenges

- Coronavirus has been the biggest challenge in providing support to Carers over the last 2 years.
- Unpaid Carers have been unable to access the same level and variety of supports services they previously had prior to Covid. This resulted in increased caring roles for many Carers.
- This impacted on carers, and increased the feelings of isolation due to lack of respite and group support. Carer services highlighted the impact on Carers physical and mental health due to respite and replacement care not being available.
- Our Carer Centres & Services worked creatively in providing alternatives to decrease the impact of missing day service support and respite opportunities.
- Our challenge is to reach all unpaid carers within Argyll and Bute, so that preventative services can be known about, accessed, and used effectively, Care homesworked hard to maintain a safe environment for their residents, but due to this there where periods when admissions had to be cancelled or delayed due to the need for caution. This reflects the national picture.
- Day services have been closed since April 2020, reducing availability of support to unpaid carers. Care at home & Home support services have been met with recruitment difficulties and a diminishing workforce, with waiting lists for services being apparent. Severe staff shortages have meant that services are currently being delivered through a range of different teams. There has however been an impact on hospital discharges and the delivery of re-ablement in the community. The level of service is also being reduced to only meet critical needs and the impact of this may affect other parts of the system including the impact on unpaid carers.

How has Covid affected your past and future intentions and priorities?

- Nationally figures show Pre-Covid 40% of carers hadn't had a break for a year, 25% had not had a break in 5 years. Only 3% of carers currently receive any statutory support. 82% of young carers had no break during Covid.
- The Covid pandemic meant we have had a delay in meeting the timescales of the commitments set out in our Carers Strategy.
- During the pandemic there was an increase in numbers of unpaid carers being registered with our carer centres. Carer services had additional challenges to ensure carers were kept connected and supported.

CARERS

What have we done so far?

- Worked with Carer Services to implement the Caring together Strategy.
- Recruiteda Carers Act Officer and a Young Carers project assistant.
- Carried out contract reviewing and monitoring.
- Built capacity within the enhanced performance team.
- Updated our Young Carers Statement.
- Increased the visibility and awareness of unpaid carers and the support they provide.
- Recruited Carer representation on the IJB.
- Carried out a consultation on Respite and Short breaks.
- Linked with the Carers Census.

What do we plan to do?

- We intend to deliver on all of our 5 priority outcomes fulfilling our 26 key commitments by completion of a wide actions over the next three years as detailed in our Carers Strategy Implementation Plan available on: **http://bit.ly/ABCarersStrategy**

CARERS

Priorities Year 1

- Continue to work closely with our Carer Centre Services to deliver on A&B Caring Together Strategy.
- We will develop a Carer APP which will assist in the sharing of information and provide guidance to carers.
- There will be a learning and development plan to support implementation and knowledge of the Carers (Scotland) Act.
- There will be multi-agency guidance for our workforce on identifying, supporting, listening to and involving Carers during the planning of services and recognising their involvement as an equal partner in care. This will include guidance on how we communicate and work together.
- Develop and implement processes to ensure that Carers Support Plans, Young Carers Statements, and Emergency Plans are completed, and the information is shared across all services as agreed.
- We will increase Communication and engagement; ensuring carer's voices are heard. Produce an Engagement framework.
- We will work collaborative with Carers and Carer centres to create a Carer Pathways.
- We will work to develop guidance to support carer visibility and involvement prior to hospital discharge.
- Review and update of our Caring together strategic plan.

Priorities Year 2:

- We will work with educational, cultural and leisure organisations to improve access for Carers to programmes and establishments across Argyll and Bute and beyond.
- In collaboration with Carers, develop a plan to ensure that feedback and input from Carers are included in all appropriate planning and decision making and within the Carers' participation and engagement statement.
- Review of the current Eligibility Criteria for Adults and Young People.
- Increase our involvement with education and raising Young carer Awareness.

Priorities Year 3:

- Review and update of our caring together strategic plan.
- Review of our Short breaks statement.

PREVENTION PROGRAMME

Current Situation

This transformation work stream was formed in the Summer of 2021 to provide a community-asset based approach to preventative, physical activity based, befriending & short breaks for adults and their carers. This approach should allow for local initiative and development while maximising any investment we have and other funding providers offer.

The work stream is aiming to;

1. Ensure that there are a range of community based services that keep adult people well, active and in their communities, this may involve expanding a range of supports and link with developments around the Primary Care Community Link Worker programme with a focus on providing preventative and enabling support.
2. Oversee expanding support for unpaid carers and continued implementation of the Carers Act.
3. To review current HSCP expenditure on these types of service and consider options to reduce duplication of service, maximise use of funding and consider models for developing or supporting community hubs across A&B, linking with the Strategic Commissioning Framework.

Challenges

Ensuring best value of HSCP funding which is currently spread across many organisations.

Ability to invest due to financial pressures.

The need to increase preventative and early intervention approaches as medium to long-term strategy to managing demand and fulfil our strategic vision.

How has Covid affected your past and future intentions and

Increased universal knowledge of public health approaches and social inequalities.

Given more time to evaluate own life and wellbeing and the impact of own health.

Increased focus on wellbeing and mental health.

Provided some new funding streams for preventative work.

Increased deconditioning, social isolation.

All of which have raised the profile of public health as everyone's business.

PREVENTION PROGRAMME

What have we done so far?

- Harnessed and affiliated existing projects and given them the strategic level oversight and support they require to progress;
    - Living Well Strategy
    - Physical Activity Group
    - Carers Act Implementation group
- Provided a central point for funding to be directed to preventative projects e.g. Flexible Funds.
- Raised the profile of prevention with a communication strategy and provided tangible plans to increase impact.
- Gained an overview of HSCP grant funded services and progressed a gap analysis against the strategic commissioning framework.

What do we plan to do?

- To increase prevention and early intervention the Transformation Board has agreed that we elevate this work stream to consider all aspects of prevention across our health and social care services by;
- Consider and support roll-out of Multi Disciplinary Team and third sector frailty models
- Propose a multi-agency programme
- Prioritising workforce education on health behaviour change
- Consultation and engagement with public and staff to evaluate readiness for prevention and how the community wish to engage with this approach. (review of engagement work undertaken so far to identify gaps first)

PREVENTION PROGRAMME

Priorities Year 1

- Establish Health Behaviour Change training within the HSCP.
- Communication & engagement plan developed and rolled-out.
- Collate ideas to increase prevention and early intervention in preparation for National Care Service roll-out.

Priorities Year 2:

- Continue training.
- Create and implement plans.

Priorities Year 3:

- Review impact of training.
- Continued implementation of plans.

DIGITAL HEALTH & CARE STRATEGY

Current Situation

ARGYLL & BUTE HSCP DIGITAL MODERNISATION STRATEGY 2022-2025

This Digital modernisation strategy has been developed to direct the operation, investment plans and future use of Information Technology (IT) and digital services in Argyll and Bute Health and Social Care Partnership (HSCP).

The prime focus of this strategy is to ensure the design of IT and Digital services and structures deliver positive outcomes for staff, service users and other stakeholders.

Challenges

- Operational managers and team leaders remain having to use 2 systems (NHS or Council) and processes to obtain patient and client information, manage staff, manage budgets, obtain performance information and order supplies. This continues to causes duplication and delay and is a waste of time and resources for the HSCP and out patients and clients.
- National NHS IT systems and local systems between health and care cannot be joined up e.g. NHS and Social Care, Payroll NHS employed staff national system, council payroll system for council employed staff.
- Improving patient's access to services alongside the need to increase efficiency and productivity will require more use of digital services and IT systems. Further notwithstanding the impact of the Covid19 pandemic it is clear this requires additional significant investment to ensure development of HSCP IT infrastructure, strengthening cybersecurity and improving resilience of its services.
- Co-locating health and social care staff has progressed integrated working of services, but with the transfer to home/hybrid remote working, the challenge is to ensure blended approach to support staff well being. However, there is now the issue of establishing an organisational digital and working culture that values this hybrid way of integrated working.
- There is expected to be a significant drive to reduce the cost, save money and increase the productivity of corporate services to fund front line services as we meet the cost of Covid19 in future years.
- The establishment of the National Care Service by 2025, will pose a significant transition and change challenge to the HSCP as it takes on new responsibilities and digital modernisation is a key requirement for the service.

How has Covid affected your past and future intentions and priorities?

Digital Modernisation

Prior to the pandemic the service was commencing a significant enhancement to address the challenges detailed above, we continue to have issues of duplication and access to respective NHS and council IT systems and difficulties in communication e.g. no single HSCP e-mail list, access to policies etc. However, there has been a significant focus on improving where possible and the pandemic enabled rapid movement in some areas with the role out our Microsoft Teams across the NHS and Argyll and Bute council have also adopted this platform.

Details of the digital outcomes we are planning to achieve within the HSCP working within the new National Health and Social Care digital strategy December 2021, and alignment with the respective strategies of NHS Highland and Argyll and Bute Council. This has shaped and informed the HSCP Digital Health and Care Strategy.

Consequently this has shaped and informed our current **Digital and IT priorities** for 2022/23 and 2023/24, which very much reflect the feedback we have received from our staff and partners and specifically our patients and clients.

Our key achievements in the last 12 months during the pandemic include:

- Delivering remote working for over 1200 users providing laptops, networks and software
- Completion of procurement for replacement of social work/community NHS Carefirst system with Eclipse. Implementation from September 2022.
- The replacement of our 7 Hospital telephone systems in May 2021, thereby facilitating digital voice modernisation going forward including expansion into primary care.
- Telecare and Telehealth significant expansion in uptake and demand for services particularly near me. Key challenge is the shift of telecare from analogue to a national digital platform within the next 3 years.
- As a first in the UK, undertaking a stage 2 trial to use beyond visual line of sight Drones to collect and deliver laboratory specimens integrated with a digital platforms to order and track specimens from surgery to laboratory.

NHS launches UK's first COVID test drone delivery service in Scotland on Vimeo

Our digital modernisation work has also improved our carbon foot print, by reducing the burden of travel on our staff across our different types of transport, Car ferry and air

DIGITAL HEALTH & CARE STRATEGY

What have we done so far?

- Responded to the pandemic by expanding and enhancing our IT infrastructure to facilitate home/hybrid working in 2021/22

  On council systems we had 289 HSCP unique users. 6,181 authentications on VPN council system – May 2020 12.000 NHS Highland users office 365 /access to teams as at July 21
- Keeping our services safe and cyber secure
- Strengthening resilience in the up time and performance of IT infrastructure
- Increasing the uptake and use of Technology Enabled Care (TEC) by clients and patients including "Near Me" video consultation platform.
- Completed the procurement and commenced the implementation of our replacement social work and community health IT system with the new "Eclipse" system as at a cost £465,000

What do we plan to do?

To achieve these aims health and care must focus on 6 priority areas: The HSCP will progress its digital modernisation by focusing on the 6 priority areas detailed in the figure attached, This will mean we will:

- Continue with co-location of health and social care corporate staff to work together in the same locations and in the same teams both physically & virtually
- Integrate health and social work administration and implement digital technology- progress digital health and care record
- Facilitate and support agile and mobile working for community based staff across the health and social car partnership including the independent sector
- Modernise and automate our admin processes and free up staff resource to support front line services
- Harness the opportunities of "big data2 and the internet of things to improve services to users, patient and clients and reduce burden of work on staff.
- Provide enhanced training and support to develop a digitally skilled workforce across health and care enhancing digital literacy

Digital access

- People have flexible digital access to information their own data and services which support their health and wellbeing whenever they are.

Digital services

- Digital options are increasingly vailable s a choice for people accessing services and staff delivering them.

Digital foundations

- The infrastructure, systems, regulation, standards, and governance are in place to ensure robust and secure delivery.

Digital skills and leadership

- Digital skills are seen as core skills for the workforce across the health and care sector.

Digital futures

- Our wellbeing and economy benefits at Scotland remains at the heart of digital innovation and development.

Digital-driven services and insights

- Data is harnessed to the benefit of citizens, services and innovation.

DIGITAL HEALTH & CARE STRATEGY

Priorities Year 1:

- Implement the new ECLIPSE IT system and increase the number of community health staff using the single health and social care IT system.
- Join up our HSCP teams by improving NHS systems and Council systems for easier data sharing. Enhance communication and collaboration using MS Teams federation.
- Complete the final phase of our "Drone" beta service for clinical logistics in the West of Argyll leading national innovation in the use of this technology in the Scottish Health service.

Priorities Year 2 and 3:

- Progress the National Care Service Implementation programme once primary legislation is in place from June 2022. Implement when defined single integrated digital services for health and social care staff as part of new CHSCB.
- Implement once for Scotland T&Cs service facilitating blended/remote working for our staff and aiding recruitment and retention.
- Complete the digital modernisation transformation projects within our records and appointment services within the NHS and social care.
- Contribute towards the achievement of net zero carbon emissions across HSCP services, working in partnership with Argyll & Bute Council and NHS Highland.
- Complete our digital transformation where more is accomplished with less because of new ways of working by enhancing the Digital literacy and skills of our workforce -

"Our people will need to train in new skills and adopt working in different ways- collaboration".

TECHNOLOGY ENABLED CARE

Current Situation

Our Telecare Service supports approximately 2500 clients to live safely at home. Equipment that is available includes falls pendants, property exit sensors, smoke/ heat sensors & bed/chair sensors.

We also use activity monitoring – Just Checking to monitor activity within the client's home supporting us to build effective care packages for client's as appropriate. This equipment can be installed for a short assessment period or longer if required.

Current project ongoing is Analogue to Digital transformation ensuring A&B has a digital solution is available when the telephone networks are fully digitalised in 2025.

NHS Near Me continues to be used widely; however there is a falling trend in usage from previous months. This is replicated nationally not exclusive to A&B. As COVID restrictions continue to ease the team's challenges continue to maintain as much activity as possible and facilitate shared learning during this time across existing and other specialties & services.

Tec team have purchased Ipads to support digital inclusion in A&B and these may be issued in a "loaning library" type way allowing citizens with no equipment to be able to attend appointments.

We are working with our Social Work colleagues at present building Near Me waiting areas for Out of Area reviews. Training is underway with staff and we are offering ongoing support while they adopt this new way of working.

Some work is also being undertaken with our Acute Care teams allowing them to link in with specialist services in Glasgow, supporting remote patient care.

Our online Cognitive Behavioural Therapy programmes continue to be used successfully and the most recent of these platforms Silver Cloud has had additional programmes added to the platform. Again training and support to our colleagues who are referring to these platforms is constant and attendance to National meetings to keep A&B at the forefront of any changes.

Challenges

- The transformation of the telephone networks from Analogue to Digital is complex and requires investment in equipment and ensuring appropriate solutions are available and suitable for clients in Argyll & Bute, particularly in areas where mobile signal is not reliable.
- Global microchip shortages are impacting on availability of equipment required.
- Pressures on Commissioned Services are often funding related
- Awareness of what TEC can offer clients is limited in Argyll & Bute
- Funding for Telecare currently comes from clients however Scottish Government proposals for National Care Systems means that funding may require to be met from the HSCP in the future.
- Near me challenges include maintaining momentum and encouraging continued use of service as restrictions ease
- Restricted Wi-Fi in hospitals will impact on Acute Care usage and Virtual visiting availability

How has Covid affected your past and future intentions and priorities?

The establishment of a virtual team of TEC Technicians meant that cover was available across Argyll and Bute much more easily. We are grateful that Care and Repair continued to install equipment in client's homes during the Pandemic (following appropriate risk assessment) to ensure that telecare was available to those who needed it.

TECHNOLOGY ENABLED CARE

What have we done so far?

- Ensured stock levels are sufficient to minimise the risk of not having appropriate equipment.
- Allocated resource (People and finance) for the investment required in the Analogue to Digital Project.
- Work in partnership with Commissioned Services to better understand pressures they face and find joint solutions.
- Continue to support planning for role out of services in Social Care.
- Continue to progress roll out within urgent care.
- Work with planning colleagues to ensure Near Me reamins part of Remobilisation Planning and re designing clinics.
- Link with North Highland colleagues in promoting digital care.

What do we plan to do?

Over the next three years we intend to increase the use of digital services and further develop TEC services within Community Teams to ensure it is a core service. We will also further develop 'Attend Anywhere' clinics in Dermatology, Respiratory and Gynaecology pressure specialities significantly reducing travel for appointments. The use of home health monitoring will be expanded to help for example titrate medication to clients, freeing up staffs time to offer more direct patient care. We will also complete our new Argyll and Bute TEC strategy, which will include the shift from Analogue to Digital technology.

More information in relation to our TEC service is available on our website at:
https://www.argyll-bute.gov.uk/social-care-and-health/argyll-and-bute-telecare-service

TECHNOLOGY ENABLED CARE

Priorities Year 1:

- Work on finding a digital solution within the pilot area.
- Continue to promote digital care across the HSCP ensuring no digital exclusion in Argyll & Bute.
- Ensure TEC is a core service embedded in all aspects of delivery of care.
- Encourage promotion of all services throughout patients/ clients journey.
- Supporting collegues to feel more comfortable using TEC available as a resource to support their delivery of care and free up time for direct patient care.
- Continue to develop NHS Near Me clinics to support clinicians in delivering remote clinics and supporting patients to attend appointments without the need to travel.

Priorities Year 2:

- Expand digital solution across Argyll and Bute.

Priorities Year 3:

- Ensure all Telecare clients have a digital solution in place.

CORPORATE SERVICES

Current Situation

Corporate services include finance, planning, performance IT including telecare and telehealth, HR, pharmacy management, medical management and, commercial vehicles "fleet" and estates, buildings and services (all be it that ownership of the assets and some operational responsibility sits outside the HSCP with NHS Highland and Argyll and Bute Council).

There is a requirement to make corporate services more productive and cost efficient and to provide an integrated service for the HSCP. The aim of corporate services is therefore to assist and support our clinical, social work and care service as the deliver front line services. Corporate services also support the governance requirements of the IJB.

The National health and wellbeing outcome indicators require HSCPs to use resources effectively and to integrate support services to provide efficiencies. The HSCP will continue work towards ensuring they focus on productivity improvement, cost efficiencies and modernisation to reduce the burden of work on operational staff.

Challenges

- Not all corporate support services from the Health Board are delegated to the partnership and none are delegated from the Council to the Partnership
- Operational managers and team leaders remain having to use 2 systems (NHS or Council) and processes to manage staff, budgets, information and order supplies. This continues to causes duplication and delay and is a waste of time and resources
- National IT systems and local systems between health and care cannot be joined up e.g. Payroll NHS employed staff national system, council payroll system for council employed staff
- Increased efficiency and productivity will require more use of digital services and IT systems and notwithstanding the impact of the Covid19 pandemic it is clear this require significant investment to ensure resilience in services
- Co-locating health and social care staff has progressed, but with the transfer to home working, the challenge is about ensure blended approach to support staff well being. However, there is now the issue of establishing an organisational culture that values this hybrid way of integrated working
- There is expected to be a significant drive to reduce the cost, save money and increase the productivity of corporate services to fund front line services as we count the cost of Covid19.
- The establishment of the National Care Service by 2025, will pose a significant transition and change challenge to the HSCP as it takes on new responsibilities etc.

How has Covid affected your past and future intentions and priorities?

Estate

- HSCP continued to progress the rationalisation of its estate with co-locating teams and also moving staff into the Council Buildings in Kilmory, this was achieved in summer 2019.
- Covid19 impact has seen the majority of our non-front facing staff in health and social care working from Home from April 2020 with rapid and significant enhancement in our digital and IT infrastructure.
- Looking forward the HSCP has evaluated the impact of this via surveys, feedback and evaluation and in line with the developing national policy will see it operate a "blended" approach with home and office working continuing. This over the next 3 years will see working with our council partners continued reduction in our estate footprint.

Digital Modernisation

Prior to the pandemic the service was commencing a significant enhancement to address the challenges detailed above, we continue to have issues of duplication and access to respective NHS and council IT systems and difficulties in communication- no single e-mail list, access to policies etc. However, there has been a significant focus on improving where possible and the pandemic enabled rapid movement in some areas with the role out our MS Teams.

The outcome of this work is about removing the burden of work on staff, increasing productivity of our front line teams, removing and automating admin tasks (record handling, printing, posting, sharing information electronically, reducing the burden of travel for staff and patients and clients etc.) Freeing up admin resource to support other front line work and produce cost saving.

- Our key achievements in the last 12 months of the pandemic include:
- Maximising remote working for over 1200 users providing laptops, networks and software
- Completion of procurement for replacement of social work/community NHS Carefirst system with Eclipse. Implementation from June 2022.
- Completion of replacement of 7 Hospital switchboard system in May 2021, facilitate digital voice modernisation going forward.
- Telecare and Telehealth significant expansion in uptake and demand for services particularly near me. Key challenge is the shift of telecare to national digital platform within the next 3 years

Argyll and Bute's **digital priorities and outcomes** for 2021-2025 which we are planning to achieve within the HSCP working within the new National Health and Social Care digital strategy December 2021 and alignment with the respective strategies of NHS Highland and Argyll and Bute Council. In addition to this our **digital and IT priorities** for 2022/23 and 2023/24 which very much reflect the feedback we have received from our staff and partners and specifically our patients and clients.

CORPORATE SERVICES

How has Covid affected your past and future intentions and priorities?

NHS Fleet Modernisation and decarbonisation

Significant work has occurred over the last 2 years to understand the suitability and use of our commercial fleet and prepare for the achievement of the zero carbon target by 2025. The pandemic resulted in a dramatic reduction in the cost of travel and use of our vehicles in 2019/20 however, this is increasing again in 2020/21 and 2021/22.

The HSCP has now electric charge points on all its hospital sites except Mull due to funding received from Scottish Government. However, we have now reached our electricity "supply" limit into our sites and require an upgrade.

The HSCP now has a fleet of 34 electric vehicles, but we still have 150 more that need replacing if we are to achieve our zero emissions target.

We have a significant challenge to achieve the carbon neutral target and the table below details our NHS vehicle lease replacement schedule for the next 3 years.

Vehicle Type

Argyll and Bute HSCP NHS Fleet replacement profile

Vehicle type	Replacement 2022/23	Replacement 2023/24	Replacement 2024/25
Cars / SUVs	54	63	10
Vans	8	8	10
Lorry	-	-	1
Tractor	-	-	-
Total	**62**	**71**	**21**

The Energy Savings Trust decarbonisation report for Argyll and Bute HSCP covering our commercial and "grey fleet" (private cars used for work purposes) is main recommendations are below, would see a reduction of 238 tCO2 from our commercial fleet.

The HSCP has also taken the national lead in exploring the use of unmanned beyond visual line of sight Drones to enhance its clinical logistics network focusing on blood specimen transportation.

This is still in its beta testing phase with our final testing of the service planned for 2022. This however, could see the HSCP adopting drones to improve the speed of diagnostic testing for our GP practices and hospitals improving care and treatment for our patients.

NHS launches UK's first COVID test drone delivery service in Scotland on Vimeo

The benefits to patients include swifter access to results and convenience, instead of being dependent upon what time the van comes to collect blood specimens.

The benefits to the organisation include reducing the burden of travel on our portering team time and distance and types of transport, ferry and air. Also the increased risk having to travel in the winter etc as well as reducing our carbon footprint.

What have we done so far?

- Responded to the pandemic by expanding and enhancing our IT infrastructure to facilitate home/hybrid working in 2021/22.
- 12.000 NHS Highland users office 365 /access to teams as at July 21.
- On council systems we had 289 HSCP unique users. 6,181 authentications on VPN council system – May 2020.
- Completed the procurement and commenced the implementation of our replacement social work and community health IT system as at a cost £465,000.

What do we plan to do?

Continue with co-location of health and social care corporate staff to work together in the same locations and in the same teams both physically & virtually.

Integrate health and social work administration and implement digital technology- progress digital health and care record.

Facilitate and support agile and mobile working for community based staff across the health and social car partnership including the independent sector.

Explore further opportunities to rationalise estates and properties by hybrid working and support the council "Our Modern workspace" project.

Continue to improve the cost and use of Health and Social care business fleet to improve service to users, obtaining funding to invest in enhancing our electrical supply to provide increase charge point infrastructure to and reduce cost and CO2 footprint achieve 2025 target.

Modernise and automate our admin processes and free up staff resource to support front line services.

Harness the opportunities of "big data2 and the internet of things to improve services to users, patient and clients and reduce burden of work on staff.

CORPORATE SERVICES

Priorities Year 1:

- Identify estate rationalisation opportunitiesas part of Councils "Our Modern Workspace" project.
- Implement the new ECLIPSE IT system and increase the number of health staff using the single health and social care IT system.
- Join up our HSCP teams by improving NHS systems and Council systems for easier data sharing. Enhance communication and collaboration using MS Teams federation.
- Obtain funding and expand our electric vehicle charging point infrastructure by 30 and our electric vehicles by 35.
- Complete the final phase of our "Drone service" beta service for clinical logistics in the West of Argyll leading national innovation in the Scottish Health service.

Priorities Year 2 and 3:

- Progress the National Care Service Implementation programme once primary legislation is approved. Support when defined single integrated corporate services for health and social care staff as part of new CHSCB.
- Implement once for Scotland T&Cs service facilitating blended/remote working for our staff and aiding recruitment and retention.
- Progress the achievement of net zero carbon emissions across NHS commercial fleet, working in partnership with Argyll & Bute Council and NHS Highland.
- Complete our digital transformation where more is accomplished with less because new ways of working with or without technology. Digital transformation is not about technology only – **Our people will need to train and adopt working in different ways- collaboration.**

PERFORMANCE MEASUREMENT - HOW WILL WE KNOW?

Performance, Outcomes & Improvement

The HSCP is committed to openness and transparency in respect of performance reporting. Due to service pressures arising from the pandemic during 2020/21, there has been some disruption to reporting as the HSCP focussed on addressing the pandemic and re-mobilisation of services. A revised Integrated Performance Management Framework is been designed and will be rolled out fully in 2022. The HSCP reviews its performance data and uses this to enable it to be responsive to emerging need and service pressures and to continuously improve and inform its strategic planning processes.

National Health and Wellbeing Outcomes

The National Health and Wellbeing Outcomes provide a strategic framework for the planning and delivery of health and social care services. These suites of outcomes, together, focus on improving the experiences and quality of services for people using those services, carers and their families. Currently there are 9 key National Health and Wellbeing Outcomes (NHWBO) and 23 sub-indicators. These form the basis of the reporting requirement for Health and Social Care Partnerships across Scotland.

Integrated Performance Management Framework (IPMF)

The Integrated Performance Management Framework (IPMF) will provide the local and national performance backdrop for strategic planning activity and also ensures that outcomes are measureable and evidenced based.

A performance framework needs to be short and clear in roles and responsibilities. Managers need to be involved in the development of the KPI's to ensure ownership and keep them relevant to their services and improved service outcomes. We need to learn from what has worked and what has not with regards to previous performance reporting. Data are accessible for all managers across health and social care.

From a cultural perspective the development of the Integrated Performance Management Framework (IPMF) will change the way managers will engage with performance and improvement. The drivers for change identify seven overarching principles which give the context and backdrop for the development and implementation of the Integrated Performance Management Framework (IPMF).

Overarching Principles

1. The Clinical & Care Governance Committee can demonstrate that the senior leadership are committed to and involved in improving the performance of the Health & Social Care Partnership (HSCP).
2. Standardise the way the HSCP manages performance and improvement- everyone will be able to identify clearly their contribution against Key Performance Indicators (KPI's).
3. Delivering a high performing culture and a consistency of approach with clear expectations and a single process which helps retain focus on key performance targets and priorities.
4. Ensures a comprehensive understanding of local performance-offering scope to look at cause and effect in the improvement journey.
5. Accurate and timely record of actions captured to ensure locality performance is visible to the HSCP and those using services.
6. Provides a forum for group problem solving and success- sharing of experience and overcoming barriers to improvement.
7. Supports the use of data to evidence both local and strategic decision making using a Best Value approach.

Key IMPF change goals are:

- We have an effective performance management framework which supports and articulates HSCP goals and objectives.
- We are able to inform and empower staff and managers with regards to what really matters and reinforcing positive behaviours.
- We are freeing-up leadership time and capacity across the HSCP.
- We are delivering improved customer service for the people who use our services.
- We are working collaboratively and communicating effectively with all stakeholders.
- We are developing real opportunities for staff training and development to support the delivery of a high performance culture.
- We are listening and gathering feedback from staff and managers to help drive and inform improvement.

FINANCIAL IMPLICATIONS - WHAT WILL WE SPEND?

Finance

The Argyll and Bute Health and Social Care Partnership is required to operate within the resources it has available to it and on a financially sustainable basis. The partnership has set a balanced budget for financial year 2022/23 and is currently developing longer term finance and investment planning. It is important that the strategic priorities and objectives of the HSCP align with its budget.

Overall the HSCP has faced significant financial challenges in recent years and these are now being addressed. The financial position is improving and our services are being better funded by government, this gives us increased scope to consider how we develop and transform our services and invest in the longer term.

2022-23 Approved Budget

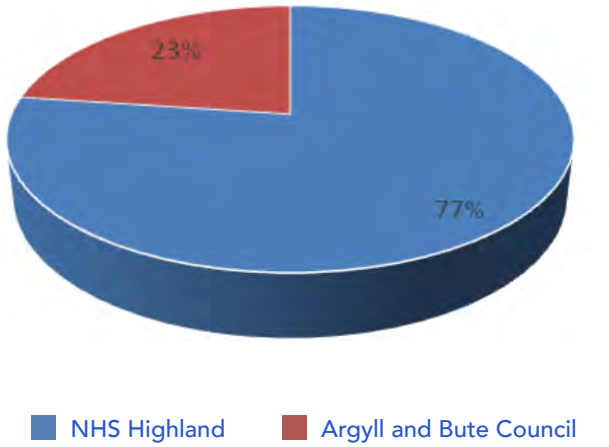
The approved budget for 2022-23 outlines our plans to spend the funding allocated to us, totalling £320.9m for the year. The HSCP is benefiting from recent commitments from the Scottish Government to better fund and priorities Health and Social Care Services. Almost all of our funding comes from Scottish Government to the two partner bodies, NHS Highland and Argyll and Bute Council who then allocate it to the HSCP. The chart summarises the current position whereby 77% of the funding originates from Health budget through NHS Highland and the remaining 23% is passed through Local Authority funding mechanisms via Argyll and Bute Council.

The HSCP has set an expenditure budget for the year which balances to the available resources. However, this requires £3.9m of savings to be delivered in year in order to achieve financial balance. This on-going need for efficiency and cost improvements is driven by on-going inflation, demand increases and the introduction of new interventions and treatments. The impact of demographic change is an important aspect of this challenge, as our population ages health and care needs increase materially while the working age population is reducing in our area.

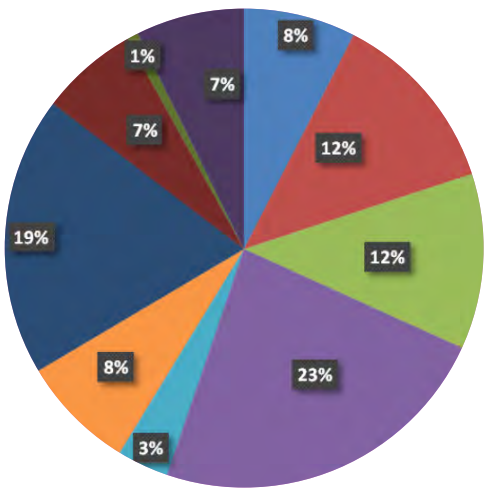
We seek to ensure that our savings plans improve efficiency and reduce costs in ways which minimise the impact on service users and the wider community.

The expenditure budget is allocated across a wide range of services throughout Argyll & Bute and with external providers, particularly related to Hospital Services in NHS Greater Glasgow & Clyde.

Argyll & Bute HSCP - Funding 2022 / 2023 £m



A&B HSCP Budget Summary



- Children & Families
- Older People social care
- Mental Health & Learning Disability & Physical Disability
- Commissioned Services incl NHS GG&C
- Dentists, Chemists and Opticians
- GP Services
- Hospital and Community Services
- Prescribing
- Public Health
- Management and Corporate

Medium Term Financial Plan

The HSCP is in the process of developing its longer term financial plan. This will sit alongside the Strategic Plan and Commissioning Strategy.

The partnership is now in much improved financial position and is able to look forward positively with service transformation and long term investment planning being prioritised. Despite the improved financial position of the HSCP, it is anticipated that the public sector in Scotland will continue to face a very challenging short and medium term financial outlook. Uncertainty relating to future funding, the on-going impact of covid and the macroeconomic outlook with high inflation, increasing energy costs and supply chain disruption adds to the planning challenge. We also expect to have to manage a backlog of treatment and longer waiting times in the coming years, these have arisen as business as usual activity reduce during the pandemic.

The HSCP will be required to continue to develop and deliver efficiency savings to offset increasing costs and increasing demand for care. This increasing demand is expected to be driven by an ageing population the introduction of new drugs and treatments and government policy. We also need to be mindful of local demographics as a reducing population may continue to make recruitment of staff challenging and may continue to feed into funding formulas and reduce the level of resource available.

The HSCP will continue to work to ensure value for money is achieved and some re-prioritisation will be required to transform the services we deliver and changing demands on the services we provide.

Financial Risks and Challenges

The key risks currently identified include:

- delivery of new and existing savings;
- general inflation and staff pay increases being higher than public pay policy;
- high levels of macroeconomic risks and uncertainty;
- costs of new treatment and demand levels for all services;
- staffing establish setting and the introduction of the safe staffing legislation;
- on-going covid pandemic; and
- sustainability of key providers and commissioned services.

There are number of factors which provide mitigation against financial risks, these include:

- high level of reserves carried into 2022/23 will help enable short term mitigation of financial risk on a non-recurring basis;
- planned activity and spend continues to be constrained by the available workforce increasing the likelihood that it will take time to grow into the increased budget;
- the implementation of the Commissioning Strategy and improved enagement with service providers and the Voluntary Sector; and
- Increased focus longer term investment and transformation.

Additionally, the commitment to the development of the National Care Service poses a significant risk of disruptive structural change which is likely to divert attention from operational and strategic priorities and planning within the coming year.

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Argyll and Bute Health and Social Care Partnership

Email: nhsh.strategicplanning@nhs.scot

Websites: https://argyll-bute.gov.uk/health-and-social-care-partnership

About Argyll & Bute (scot.nhs.uk)

www.facebook.com/abhscp

www.twitter.com/abhscp

If you would like to share feedback on the Joint Strategic plan and/or Specific Individual area. Please share your comments and feedback via our online survey click here. A paper Survey can be requested please contact nhsh.strategicplanning@nhs.scot

This page is intentionally left blank

Argyll & Bute Health and Social Care Partnership
Strategic Plan 2022/23 – 2024/25

LOCAL HOUSING CONTRIBUTION STATEMENT

Prepared by Argyll & Bute Council Housing Services and
approved by Argyll & Bute Strategic Housing Forum, March 2022

1.0 Introduction

This is the third Argyll and Bute Housing Contribution Statement (HCS) which builds on the positive joint working that has been established across the housing, health and care sectors since the inception of the HSCP's Strategic Plan in 2016. It provides the focus for strategic coordination between the council's housing service, local housing associations (Registered Social Landlords or RSLs), other housing agencies, and the HSCP; and will ensure that the Local Housing Strategy (LHS) and Strategic Commissioning Plan are aligned when they relate to health and housing. This strategic coordination requires:

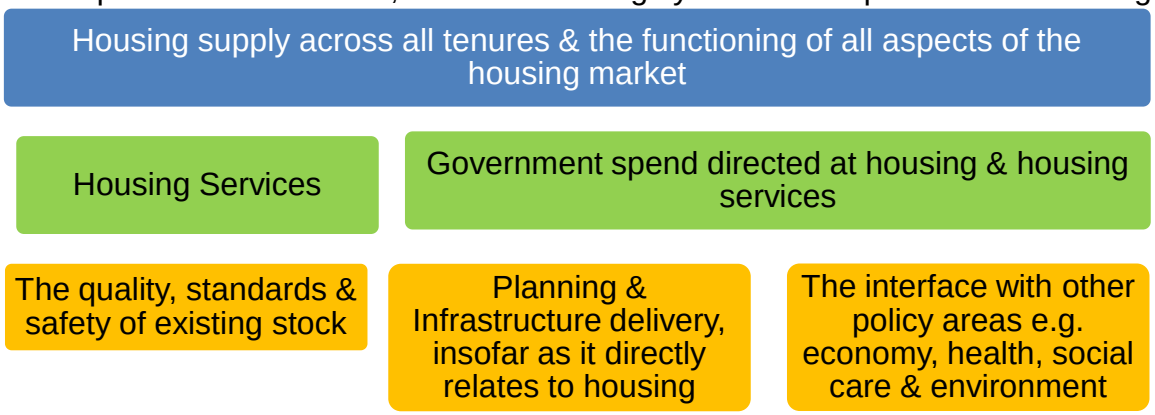
- Involvement of housing representatives in the integration authority's strategic planning group and localities;
- Shared work on the needs assessments underpinning the SCP and LHS; and
- Production of a Housing Contribution Statement as an integral part of the SCP to explain how services have been aligned.

Following current guidance, the Housing Contribution Statement is required to:

- Briefly articulate the role of the local housing sector in the **governance arrangements** for the integration of health & social care;
- Provide a short overview of **the shared evidence base** and key issues identified in relation to housing needs and the link to health/social care;
- Set out the **shared outcomes and service priorities** linking the Strategic Plan and Local Housing Strategy;
- Set out the current and future **resources and investment** required to meet these shared outcomes and priorities, and identify where these will be funded from the integrated budget and where they will be funded by other (housing) resources;
- Provide an overview of the **housing-related challenges** going forward and improvements required.
- Cover **key areas such as adaptations, housing support and homelessness**. It will also aim to articulate the housing contribution across a wide range of groups including older people and those with disabilities, mental health and addictions.

2.0 Background and progress, 2019/20 – 2021/22

As the previous HCS stated, the local housing system encompasses the following:



As strategic housing authority for Argyll and Bute, the council has legal responsibility, for:

In summary, the housing system comprises:

The Statutory Strategic Housing Authority	• Argyll & Bute Council
The Social Rented Sector	• HOMEArgyll - ACHA, Dunbritton, Fyne Homes, Link Group, West Highland • Specialist RSLs - Bield, Trust, Key Housing, Blackwood, Cairn, Cube/Enable
The Private Rented Sector	• Private Landlords & tenants; Letting agents; • Community Groups, Development Trusts
The Owner Occupied Sector	Home Owners

The wide range of housing services available in Argyll and Bute include: Strategic planning, new build development and empty homes; Homelessness, housing options and information and advice; Tenancy support, mediation, money skills; Welfare Rights, income maximisation, and benefits; Private sector property repairs and improvements; Aids and adaptations, and Care & Repair; Home energy efficiency, fuel poverty and climate change initiatives; Factoring, estate management. All of these, and other particular functions, have a positive impact on the health and well-being of the local population; and will continue to make a real and significant contribution to the outcomes of the HSCP's strategic plan.

Table 1: HCS Progress/Outputs 2019/20 – 2021/22	
Action	**Milestone/Output**
Using evidenced based need and demand to identify specialist housing requirements early in the development of the SHIP and SLP.	The new Argyll & Bute Housing Need & Demand Assessment (HNDA) was approved as "robust and credible" by the CHMA in 2021, with specific positive commendation for the section on Specialist Provision & particular needs.
Early engagement with health and social care partners (e.g. OTs, learning disabled team) in the planning for the SHIP, help inform practical design issues	Following an initial fixed-term appointment, the dedicated post of Housing OT was confirmed as permanent and fully funded by Housing Services in 2021; and has continued to enhance planning processes and engagement across the sectors.
A more co-ordinated approach across housing, health and social care to address homelessness	A key outcome of the Argyll & Bute Rapid Rehousing Plan was the appointment of a Mental Health & Addictions Officer, with funding from the Council Housing Services, to ensure closer engagement for homeless cases, particularly those with complex and/or multiple health issues. 110 homeless cases with health related issues (i.e. physical or mental health; drugs/alcohol; or unmet need for support/care) received a positive outcome during 2019/20 and 2021/22.
Ensuring housing improvements and home energy efficiency programmes are targeted at the most vulnerable and fuel poor households.	The Home Energy Efficiency Programme Scotland: Area Based Scheme delivered 547 improvement measures to 428 homes with total grant aid of £2.571m (2019/20 & 2020/21 only).
Ensuring allocation policies and access to social rented housing does not present barriers to those with particular needs	Despite covid restrictions, approx.1,675 households secured RSL tenancies (years 1&2 only) of which 20% (340) were to specialist housing/ households with disabilities or health conditions.
Increasing the supply of suitable affordable housing across an appropriate range of models and types and tenure, as appropriate, to meet local need and reverse population decline.	The SHIP delivered c. 225 affordable new build homes, including around 20 specialist units (wheelchair, amenity, specially adapted) in years 1& 2 and first 3 quarters of year 3. In addition 66 empty homes were brought back into effective use in years 1&2. Around 16% of RSL stock is designated as specialist provision (and a significant proportion of the ground floor, mainstream stock would also be accessible and suitable for future adaptation)
Ensuring housing services help to tackle & eradicate health inequalities; and address disadvantaged individuals and communities.	In 2021, Health Impact Assessment completed for new LHS along with positive assessments for Equalities & Socio-Economic impact, Child Rights & Well-being, and Islands Communities. In 2019/20, 135 private homes & 237 RSL homes were adapted with grant aid; and in 2020/21, under covid, 63 private homes & at least 112 RSL homes also received adaptations.

Overall, progress against the key aspects of the HCS are positive (coded green below) despite the significant impact of the pandemic on delivery of services in years 2 & 3 of the previous strategic plan. While certain issues require further work (coded amber below) there are no areas which have failed to progress to at least some extent.

Governance	Senior Council Housing Officers and representative RSL CEOs continue to participate in the HSCP Strategic Planning Group; and senior management from the HSCP attend the Argyll & Bute Strategic Housing Forum. During the pandemic, regular cross-sectoral meetings were established including virtual "huddles" which have led to greater engagement & synergies.
Shared Evidence Base	Following the 2018 Joint Housing, Health & Care Needs Assessment, the revised HNDA 2021 includes dedicated research on and engagement with wheelchair users, Gypsy/Travellers; Armed Forces veterans; Learning Disabled and others with particular housing & support needs. Joint working with the new Housing OT has also improved data analysis for these groups.
Shared Outcomes & Priorities	A full review of the Health Impact Assessment for the new LHS in 2021 helped to identify a number of service priorities across the partnership. The Housing OT work plan was developed from the previous HCS action plan and feeds into the shared LHS outcomes & targets which were agreed through a series of option appraisal workshops & strategic conferences over last 3 years.
Future challenges & improvements required	Key issues previously identified remain priorities: delivering appropriate services & solutions in the remote rural & island context; agreeing specific project objectives, such as joint responsibilities/opportunities for re-provisioning of care homes and delivering effective range of housing/ care models in local areas; tackling health-related issues for key clients such as homeless; and improving adaptations services across all tenures.
Resources/ Investment	This was highlighted at national level as the main area of weakness in the first round of HCS; and while significant progress has been made over last 3 years, with Housing investment in support of HSCP plans being clearly identified, further work remains to be progressed in respect of specifying where investment will come from Integrated HSCP budgets or other sources.
Monitoring & Evaluation	Positive progress has again been made, and the SMART action plan for this HCS has been developed as part of the HNDA/LHS planning process with HSCP colleagues and following wide consultation with stakeholders over the last 3 years. Progress will continue to be reported on a quarterly and/or annual basis to the Strategic Housing Forum and to the HSCP's Strategic Planning Group.

Each of these HCS elements are further outlined in the following sections.

3.0 Governance Arrangements: Partnership Working and the Strategic Housing Framework

The Strategic Housing Forum

In Argyll and Bute, the overarching body with responsibility for overseeing the delivery of the LHS and the Strategic Housing Investment Plan (SHIP) is the Argyll and Bute Strategic Housing Forum which comprises a range of key community planning partners and meets quarterly. It is chaired by the Council Housing Spokesperson and administered by the Council's Housing Service but also involves other council services such as Planning and Economic Development; and external partners such as the Scottish Government, local and national RSLs, Highlands & Islands Enterprise, the Loch Lomond & Trossachs National Park, Argyll & Bute Care & Repair, ALIenergy, Home Energy Scotland, Communities Housing Trust and others. Health and Social Care representation on the Forum has been consolidated in recent years with senior management from the Integrated Authority now established on the core membership of the Forum.

Housing Sector involvement in HSCP Policy and Decision Making

Planning Structure	What we Intend to do
Integrated Joint Board	While the Housing Sector is still not represented directly on this first tier governance body of the HSCP, the intention remains that all relevant housing issues considered by the board should be fed back to the Strategic Housing Forum by the appropriate senior HSCP delegate as required.
Strategic Planning Group	At this level, the Council's Team Lead for Housing Strategy continues to ensure that necessary linkages are maintained between the LHS and the SCP and that further opportunities for joint working are identified. The RSL sector is also represented on an ad hoc basis, with individual landlords from the HOMEArgyll partnership sharing responsibility to attend and to articulate the views of the social rented sector and provide a practitioner perspective. However, ensuring appropriate feedback is provided, primarily via the Strategic Housing Forum, remains critically important.
Care Homes & Housing Working Group	This work strand was resumed in 2021, after a hiatus, and the working group provides an overview of the project work, direction, authorisation, accountability and support for the delivery of strategic change projects for care homes and housing. Senior managers from the Council Housing Services liaise with Lead Allied Health Professional, Housing OT, and Service Improvement Officer from HSCP.

Locality Planning Groups	Following a hiatus, Area Locality Groups are due to be revised and reconvened, and area housing managers and other officers will participate in these meetings as appropriate.
TEC Hub / TEC Digital Steering Group	The TEC Digital Steering Group explores all opportunities for technological support & improvements to HSCP clients within their homes; and housing has been established as a key work strand in relation to this objective. The Group proposed to establish a TEC Housing & Health Forum, following joint events held over the last 3 years.

Over the life of the previous Strategic Plan and HCS, from 2019/20 to 2021/22, a network of cross-sectoral arrangements has been established to facilitate effective strategic and operational engagement between Housing, Health and Social Care, including inter alia:-

- **SHIP Operational Group** – Council Housing Services, RSL Development Officers, Scottish Government Area Team, Housing OT, and on an ad hoc basis associated HSCP staff monitor, review and prepare updates of the Strategic Housing Investment Plan on a quarterly schedule.
- **Local Area Operational Groups** – a network of local operational groups comprising key area Housing officers from council and HOMEArgyll partners, the Housing OT and local OTs, focusing on specific casework and local issues/priorities, including assessment reviews of waiting list applicants with medical needs points and effective matching of RSL allocations
- **HOMEArgyll Steering Group** – Housing OT & Mental Health & Addictions Officers now attend these sessions
- **Learning Disability Steering Group** – Housing Strategy Manager attends this group on a regular basis.
- **Alcohol & Drugs Partnership -** Housing Strategy Manager attends this group on a regular basis, with Housing OT.
- **Adult Protection Committee** – Housing Strategy Manager attends this group on a regular basis.

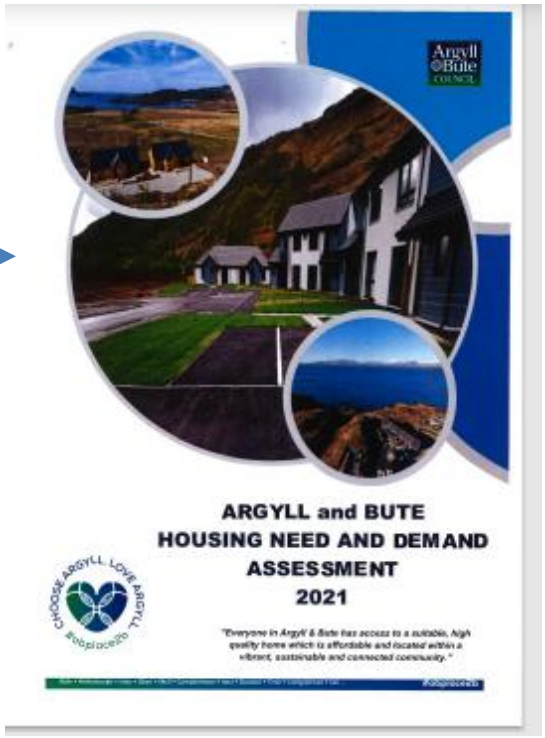
In general, therefore as recorded in the previous HCS, the higher level, strategic co-ordination across housing, health and social care continues to be reasonably well-established and strong connections remain in place. Over the next 3 year phase of the SCP and HCS, it is our intention to engage the wider housing sector as far as possible, and continue to enhance community consultation at a locality level.

4.0 Shared Evidence and key issues

4.1 The Health, Care & Housing Needs Assessment produced jointly by NHS Highland and the Council in 2018, helped to inform a comprehensive revision of the Argyll & Bute Housing Need and Demand Assessment (HNDA) which also involved a range of primary research, secondary data analysis and stakeholder engagement, and was completed in 2021.

- HNDA Technical Supporting Paper 08: Specialist Provision in Argyll & Bute, 2021
- HNDA Technical Supporting Paper 09: Veterans & Armed Forces, Argyll & Bute Council, 2021
- HNDA Technical Supporting Paper 10: Gypsy/Travellers, Argyll & Bute Council, 2021
- HNDA Technical Supporting Paper 11: Wheelchair Users, Argyll & Bute Council, 2021

- Helensburgh & Lomond Housing Market Study, North Star/Argyll & Bute Council, 2018
- Argyll & Bute HNDA Household Survey, Research Resource/Argyll & Bute Council, 2019



Simultaneously, the HSCP was developing a refreshed Joint Strategic Needs Assessment (JSNA) to underpin their new Strategic Plan.

4.2 The HNDA is a statutory duty for local authorities, and as a key requirement it must identify the need for "specialist provision" for persons with particular needs to enable independent living. This refers to both "bricks and mortar" accommodation and support services, under 6 specific categories:

- Accessible and adapted housing;
- Wheelchair housing;
- Non-permanent housing e.g. for students, migrant workers, refugees;
- Supported provision e.g. care homes, sheltered housing, hostels/refuges;
- Care/support services for independent living;
- Site provision e.g. pitches for Gypsy/Travellers or Travelling Showpeople

Council officers responsible for developing the HNDA have consulted with their counterparts in the HSCP, in particular the Senior Information Analyst, Public Health, and liaised on the shared evidence base. There is a strong commitment to ensure this process is further developed and a key action for both the new LHS and the HSCP Strategic Plan is to continue to promote closer alignment of the HNDA and JSNA processes, with a view to sharing evidence, identifying needs and planning for solutions across health, social care and housing.

As far as possible, the HNDA aims to analyse data at a sub-authority level based on 9 housing market areas (HMAs) which have been identified within the local authority boundaries. These HMAs should allow for data to be further aggregated or disaggregated as required. The HMAs in relation to the revised structure of four HSCP localities are summarised in the following table.

Housing Market Area	HSCP Locality
Bute	Bute & Cowal
Cowal	
Helensburgh & Lomond	Helensburgh & Lomond
Mid Argyll	Mid Argyll, Kintyre, Islay (excludes Colonsay)
Islay, Jura & Colonsay	
Kintyre (plus Gigha)	
Lorn	Oban, Lorn & the Isles (includes Colonsay)
Mull & Iona	
Coll & Tiree	

4.3 The Argyll and Bute housing profile, updated as of 2020/21, is summarised below.

ARGYLL & BUTE HOUSING MARKET PROFILE 2020	
Population	**85,320**
Households	**41,723**
Dwellings	**48,285**
Ineffective Stock (Empty Properties & Second/Holiday Homes)	**11%**
Average House Price	**£173,280**
Average Household Income	**£37,091**
Affordability Ratio	**4.7**
RSL Stock (Social Rented Housing)	**18% (8,629)**
HOMEArgyll Waiting List (Active Applications)	**2,469**
RSL Stock Turnover (Annual Lets)	**810**
Pressure Ratio (Nos of applicants per available let)	**3:1**
Private Rented Sector	**12% (5,822)**

Household Type, Principal Projection, Argyll & Bute, 2021-2031

Household Types	2021	2026	2031	% change 2021-2026	% change 2021-2031
Single Person	15,996	16,061	16,021	0.4%	0.2%
1 adult & 1+ children	2,153	2,011	1,919	-6.6%	-10.9%
2 adults	14,426	14,664	14,423	1.6%	0.0%
2+ adults & 1+ children	6,101	5,618	5,318	-7.9%	-12.8%
3+ adults	2,959	2,816	2,611	-4.8%	-11.8%

Source: Household Projections for Scotland (2018-based), NRS, 2020

Total Housing Stock (all tenures) by HMA, 2020

HMA	Stock	% of A&B Total	Ineffective Stock
Bute	4,247	8.8%	19%
Coll & Tiree	680	1.4%	32%
Cowal	8,722	18.1%	11%
Helensburgh & Lomond	12,171	25.2%	5%
Islay, Jura & Colonsay	2,180	4.5%	16%
Kintyre	4,171	8.6%	11%
Lorn	8,604	17.8%	8%
Mid Argyll	5,659	11.7%	13%
Mull & Iona	1,851	3.8%	15%
Argyll & Bute	**48,285**	100.0%	11%

Source: Argyll & Bute Council Tax Register, 2020

Estimated Total RSL Stock by Property Type, March 2021

RSL	Total Stock	*Mainstream Stock*	*Specialist Stock*	*Specialist Stock as % of Total*
ACHA	5221	4855	366	**7%**
DHA	466	371	95	**20%**
Fyne*	1617	1185	432*	**27%**
WHHA	790	758	32	**4%**
HOMEArgyll	**8094**	**7169**	**925**	**11.4%**
Other RSLs**	585	*132*	*453*	**77.4%**
A&B TOTAL	**8679**	**7301**	**1378**	**16%**

* Fyne Homes' specialist stock total includes 127 properties defined as "Other Specially Adapted". Figures **for** general, mainstream adapted properties are not included in the other RSL totals.
**Other non-HOMEArgyll RSLs include: Bield, Trust, Key Housing, Blackwood and Cairn

HOMEArgyll RSLs Specialist Stock by Type

ACHA	Amenity Disabled	Amenity Elderly	Sheltered	SELG Elderly
Specialist Stock	**7**	**40**	**200**	**119**

DHA	Special Adapted	Ambulant Disabled	Amenity	Wheelchair
Specialist Stock	**3**	**16**	**69**	**7**

FYNE Homes	Ambulant Disabled	Amenity	Extra Care	Medium Dependency	Wheelchair	Other Adapted
Specialist Stock	**34**	**192**	**24**	**21**	**34**	**127**

West Highland	Ambulant Disabled	Other Special Adapted	Medium Dependency	Wheelchair
Specialist Stock	**14**	**1**	**1**	**16**

- Around 5% of the affordable housing supply available for allocation each year is specialist housing. This amounts to approximately 130 homes p.a. (N.B. 2020/21 is excluded from calculations given the anomalous circumstances and constraints on allocation during the lockdown period)

HOMEArgyll Lets by Property Type, 2016/17 – 2019/20

House Type	2016/17	2017/18	2018/19	2019/20	4 Year Totals
All Types	1,019	884	928	849	3,680
Amenity for elderly	32	30	30	37	129
Housing with Support	3	3	2	2	10
Sheltered Housing	32	38	43	22	135
Wheelchair	14	5	3	2	24

General Needs	919	806	847	786	3,358
Gypsy/Traveller Site	4	2	2	0	8
Other (mainstream)	15	0	1	0	16

4.4 The social rented sector (RSL provision) in Argyll and Bute includes the following specialist accommodation suitable for persons with particular health or care needs.

Accessible and Adapted Housing: includes -

- Amenity Housing for older or disabled persons – design is based on the standards of general needs housing with some additional features shared with sheltered housing but there is no warden and a community alarm may or may not be fitted.
- Ambulant Disabled Housing – consists of dwellings for people with disabilities who are not confined to wheelchairs. Built or adapted to general needs housing standards but has level or ramped approach, WC and bathroom at entrance level and other special features
- Medium Dependency accommodation
- Mainstream/General Needs accommodation which may have been adapted
- Other Specially Adapted Housing – homes with other adaptations, such as renal dialysis equipment, and bespoke designs for those with complex needs.

Wheelchair Housing

- This consists of dwellings for people confined to wheelchairs. It is built or adapted to give extra floor space, whole house heating, and special bathroom, kitchen and other features.
- Sheltered wheelchair housing – design is adapted to wheelchair standards but also has the features listed below for sheltered housing. It is for elderly people confined to wheelchairs, rather than for other such disabled people.

Supported Provision: includes**-**

- Sheltered Housing. The design is based on the standards for general needs housing with all the additional features of amenity housing (eg space standards, handrails, bathroom features, heating system standards, accessible light switches and socket outlets, etc.) PLUS a warden service may be provided and an emergency call service should be provided.
- Very Sheltered Housing. This form of housing (sometimes known as “care” and “extra care” housing) generally has all the features listed for sheltered housing, but will usually have special bathroom facilities. In addition, a greater level of care and support is offered through the service of extra wardens, full-time carers or domiciliary assistance and the provision of meals.
- Retirement Housing.

Home Care and Assistive/Smart Technology – This has an important role in supporting independent living, and is usually associated with the occupant rather than the property. This can be provided in existing homes or in new build

provision; and as far as possible the Housing Sector will explore and support assistive/smart technology capabilities, ensuring flexibility to tailor the provision to individual needs.

4.5 Key findings of the Housing Need & Demand Assessment, 2021

In summary, the HNDA identified:-

- Increasing demand for 1/2 bedroom properties with population aged 75+ increasing by nearly 3,000 people over the next decade; and potential additional demand if Council targets are achieved for increasing the younger economically active population.
- Continuing demand for aids and adaptations across all tenures, with resource pressure and waiting list evidenced from an average annual spend of £1.3m across all tenures and an anticipated 250 persons or more per annum requiring adaptations to RSL homes over the next three years.
- With more people managing long term health conditions living in their own homes with increasingly complex health and social care needs, the need for aids, adaptations and support at home is likely to increase.
- Changing care home use means that new care home placements are for people with greater dependency and there are higher turnover rates.
- Challenges to the provision of Home Care (particularly in some local areas) leading to delayed discharges in hospital.
- Falling demand for sheltered/warden housing models, with empty properties/voids in some areas.
- An ongoing need for closer working between services at a local level to identify individuals and families in need of specialist housing provision and match them to current and future housing.
- The HOMEArgyll waiting list identifies applicants with particular needs and health-related conditions which can be adversely affected by their housing circumstances. As of January 2022, over 95% of the registered applicants either required or would accept mainstream, general needs accommodation. Only 69 applicants (or 139 including those with nil points and those on the internal transfer list) stated that they specifically required specialist provision and would *not* accept mainstream housing.

HOMEArgyll Waiting List Applicants by House Type, 2022

House Type	% of Total Waiting List, 2022
General Needs	95.2%
Specialist Provision ONLY	4.8%
Housing with Support	6.5%
Wheelchair	4.6%
Amenity for Older Persons	10.6%
Sheltered for Older Persons	7.4%

NB. Applicants can select multiple options therefore %s do not sum to 100.

- As part of the Housing Need & Demand Household Survey, local households were asked a range of questions on need for specialist forms of housing across Argyll & Bute. 4% of households with a life limiting illness or disability stated they do require specialist housing. This equates to 334 households

across Argyll & Bute. Based on evidence from the HOMEArgyll Common Housing Register and the 2019 HNDA Survey, it is estimated that approximately 200-300 households may require specialist forms of housing across Argyll & Bute.

Homelessness

In terms of other particular needs categories, a key area for further exploration will be health and care related needs of the Homeless. While homeless presentations have reduced significantly in Argyll & Bute in recent years, due primarily to the effective delivery of the Housing Options information & advice service, evidence suggests that people who are homeless can experience some of the worst health problems in society and are more likely to have unhealthy lifestyles and complex needs which lead to long-term health issues or exacerbate existing problems in a self-perpetuating spiral. In January 2022, there were 224 live homeless cases recorded in Argyll and Bute (marginally higher than in 2019), of which 6 had a self-defined physical health issue; 9 had mental health issues; 6 had drug or alcohol issues; and only 1 expressed an unmet need for support from health/care providers (all incidences of health, addictions and support needs are notably lower than was recorded in the previous HCS in 2019). Over the last three years the average length of time to close all homeless cases was 30 weeks, however the average time for those with drugs or alcohol related issues was double this, at 53 weeks.

The incidence of physical ill-health, depression and substance misuse issues is significantly higher amongst homeless people and those living in poor housing conditions; and, at a national level, hospital admissions for this group are far in excess of the population living in settled accommodation. Those at risk of homelessness and people living in unstable or vulnerable housing, including non-permanent accommodation, overcrowding and homes in poor condition also must be considered in relation to the impacts on health and can benefit from some form of housing contribution. Young single males are particularly affected in this group, but children in homeless families and women subject to domestic abuse are also client groups with particular housing and health or social care needs. There is an ongoing requirement to maintain an adequate supply of suitable temporary accommodation, with local-authority leased properties being preferred (RSL accommodation in general is most effectively utilised as long-term, permanent accommodation) and a primary focus on smaller units, mainly for single persons.

4.6 Priority: Shared evidence

Outcome: Ensure that planning for services is based on robust data and information

Aim: Continue to enhance the connections between the HNDA and JSNA processes

What we said we would do	What we did
Improve comprehensiveness and consistency of OT caseload data. Review protocols for data capture to enable reporting of OT caseload data that includes a breakdown by type of service provision, household type and long-term conditions, by local area	Due to staff turnover and the constraints on HSCP & OTs since March 2020, as a result of the Covid pandemic, this action has not progressed. Further work and a possible pilot exercise will be explored early in the life of this new Plan, co-ordinated by the Housing OT Management Group.
Continue to work in collaboration to develop strategic documents. Argyll and Bute Council Housing and Argyll and Bute HSCP Public Health will continue to work in collaboration to further understand housing needs, particularly recognising a current gap for those with Mental Illness, people with autism and for those who experience homelessness.	Collaborative working on the "specialist provision" section of the revised HNDA helped to enhance the existing evidence base and built on previous analysis, with a particular focus on the requirement for wheelchair accommodation. The health and care needs of key groups such as Gypsy/Travellers and veterans were also targeted. However, while some progress was made regarding older people and those with dementia further consideration will be required over the next 3-5 years.

5.0 Shared Outcomes and service priorities

5.1 Following extensive stakeholder engagement over the last three years, the fully revised and updated Local Housing Strategy for Argyll & Bute, 2022 – 2027, sets out the agreed joint vision and high level aims which also underpin this latest iteration of the Housing Contribution Statement.

LHS Vision

"Everyone in Argyll & Bute has access to a suitable, high quality home which is affordable and located within a vibrant, sustainable and connected community"

Four key LHS Outcomes/Priorities			
1. HOUSING SUPPLY & PLACEMAKING	**2. HOUSE CONDITION, ENERGY EFFICIENCY & POVERTY**	**3. SPECIALIST PROVISION & INDEPENDENT LIVING**	**4. HOUSING OPTIONS, INFORMATION & SUPPORT**
To facilitate access to sufficient, suitable and affordable housing across all tenures	**To regenerate communities by improving the quality, condition and energy efficiency of housing and by tackling fuel poverty**	**To enable people with particular needs to live independently in their own homes and to remain in their communities**	**To promote individual housing options to meet housing need and ensure everyone has access to appropriate, accurate and timeous information, advice and assistance**

While Priority 3 clearly has the most explicit relevance in the context of the HSCP's Strategic Plan, each of these four outcomes will make a strong contribution to the integration agenda and to local health and social care objectives.

The LHS vision and outcomes will support the overarching objectives of both the HSCP Strategic Plan and the Argyll and Bute Outcome Improvement Plan, as well as helping to address the national housing, health and well-being outcomes for Scotland. The housing sector, via the LHS, has an important and direct contribution to make to these national health and well-being outcomes as well as the local service priorities identified in the HSCP Strategic Plan. The housing contribution is particularly relevant to national

Outcome 2: “People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community”. This will involve the provision of good quality, suitable housing to support a range of needs; as well as housing support services to sustain homes and tenancies; other forms of specialist provision such as aids, adaptations, smart technology and other equipment; and preventative measures including timeous information, advice and assistance in tackling fuel poverty, improving energy efficiency, or maximising income through welfare rights assistance.

Housing can also contribute to other national health outcomes such as Outcome 9: “Resources are used effectively in the provision of health and social care” where effective housing solutions and policy interventions can prevent crises arising and obviate costly health and social care responses. The Social Return on Investment, and financial benefits of preventative spend, from Housing sector investment have been well documented in recent years, particularly in respect of significant savings to the health and social care budget from early investment in adaptations, specialist accommodation, and services tackling fuel poverty and homelessness.

It should also be recognised that Housing staff provide key local connectivity through regular contact with, and visits to, service users, tenants and estates. Improving/enhancing linkages between housing and HSCP staff will ensure early interventions as required to prevent, where possible, the need for more expensive care or hospitalisation at a later stage. Frontline housing staff can identify vulnerable tenants or prospective tenants. Knowing who to contact to ensure these people are getting the services they require is a valuable link in the HSCP Integration agenda. RSLs have a track record in partnership working, involving delivery of a range of services and projects that go beyond the ‘bricks & mortar’ of housing provision. Such ‘wider-role’ activities include welfare advice services, social, community, environmental and employment initiatives, many of which have direct or indirect links to improving the sustainment of peoples’ lives in town and rural communities.

5.2 LHS Outcome 3: Specialist Provision & Independent Living: Key Actions & Targets

The requirement for specialist provision will be met by:

- Delivering the vision and objectives set out in the Argyll & Bute Housing Contribution Statement; and fully implementing the jointly agreed Housing OT Action Plan
- Ensuring effective provision of sufficient and appropriate aids and adaptions to meet identified needs across all tenures;
- Maximising the use of assistive technology to allow people to continue to live independently in their own communities and working with partners to deliver the TEC in Housing charter;
- Continuing to work with Care & Repair and other partner agencies to deliver effective services that support independent living;
- Delivering SHIP targets for new build specialist housing, including wheelchair targets; and ensuring early engagement with HSCP in the design process;
- Monitoring and encouraging regular engagement with equalities groups, including Gypsy/Travelers, to inform service improvement

In addition, partners will focus on early engagement and intervention to meet need for specialist provision by: coordinating intelligence sharing, improving awareness of support services; and having forward planning conversations with individuals and their families.

LHS Outcome 3: Key Targets 2022-2027
At least 10% of affordable new builds should comprise some form of specialist provision, including 5% specifically for wheelchair accommodation
The overall stock of specialist housing in the RSL sector will be increased
Identified needs for adaptations to existing homes will be addressed within the life of the strategy
The proportion of households who are elderly, contain vulnerable children, or have a disability, achieve at least similar rates of positive outcomes via PREVENT1 assistance as the general population.
Official Gypsy/Traveler sites meet the recommended national standards
Levels of Gypsy/Traveler satisfaction with sites & services will be sustained or increased
Further research will be undertaken on specific equalities groups as required, including any particular needs of disabled children and younger adults, to enhance the evidence base and inform future updates of the HNDA

The detailed Action Plan for LHS Outcome Three is set out in the annex to the strategy, available on the council website via the following link:

https://www.argyll-bute.gov.uk/housing/housing-strategies-consultations-and-research-0

6.0 Housing-related challenges and service improvements required.

In delivering an effective, balanced housing system in Argyll and Bute there are a number of remaining and emerging challenges which impact on the housing contribution to health and well-being objectives.

6.1 Improving strategic and operational structures and partnerships

While some progress has been made over the last three years towards a more streamlined and efficient approach to service planning and delivery, further focused improvement in respect of effective linkages and joint working processes across the housing health and social work sectors remains critical. There is also still a need to improve understanding and share greater awareness of the different sectors throughout and across all agencies and at all levels.

What we said we would do:	What we did
Complete an initial mapping exercise of engagement structures and existing networks across housing, health & care services; and thereafter ensure this is maintained on an annual basis.	The aim of this exercise was to reduce duplication of meetings, to improve awareness of appropriate communication channels, and to ensure appropriate decision-making structures are in place. Further work is required to progress this action.
A training programme is to be delivered by the Housing OT and Council Housing Officers, which will aim to engage local staff in joint learning and raise mutual awareness.	The iHub training was launched in 2019/20, as a joint initiative, and a first round successfully completed for a range of staff across Argyll & Bute. A refresh or second round of targeted training will be reviewed.
A review of common terminology remains an important requirement (e.g. in relation to housing models, there is a need to establish clear, definitions of “amenity”, “ambulant disabled”, “sheltered”, “very sheltered”, “extra care” and “progressive care” housing, as well as clarifying distinctions in terminology regarding housing support etc. A general understanding of, and adherence to, Scottish Government definitions would be a fundamental step towards consistency).	Through the stakeholder engagement & consultation processes for both the HNDA and LHS, improvements have been made in respect of awareness, understanding & consistency of terminology. Further improvements on joint understanding of particular housing & care models will be helpful to inform and enhance the Care Homes & Housing work strand for example and other aspects of joint planning and service delivery. Housing services will collate a briefing paper on this.

What we said we would do:	What we did
Local group structures will be developed or enhanced to facilitate effective and efficient joint working at an operational level. While there is a need to avoid duplication of structures, it is also important not to add to the complexity of the often unwieldy locality planning groups.	Established an operational focus on local area officer groups (RSLs, OTs & Council Housing Services), with Oban recognised as an effective exemplar model. HOMEArgyll Steering Group; SHIP Officers Group; and the Care Homes & Housing Steering Group also key.
In moving forward with the integration agenda, Housing will continue to remain focused on the strategic outcomes and seek to ensure that all partners are involved in decision-making, and that there is cohesion and coordination between individual housing organisations themselves in order to present a unified contribution to the health and social care partnership.	Ongoing partnership working, particularly via the Strategic Housing Forum has helped consolidate the housing partners approach to engagement with HSCP. RSLs' SHIP submissions for Council Funding for instance must now evidence liaison with HSCP/OTs and show that any particular needs have been considered in project proposals.
Following the appointment of a dedicated Housing OT, Housing Services will aim to extend and sustain this post in the future to facilitate cross-sectoral planning for the delivery of appropriate Specialist Provision, by securing complementary funding where possible.	The Housing OT post was made permanent in 2021 with the Council Housing Service providing full funding. The HSCP provides administration and line management for the post, liaising with Housing Services Management.
Housing Services will ensure regular (quarterly and annual) reports on the LHS and SHIP, amongst other performance updates, are submitted to the local and central groups within the HSCP hierarchy.	LHS/SHIP progress reports are disseminated via members of the Strategic Housing Forum, and published on the council website for general access.

6.2 Addressing the key drivers of the local housing system

The wider environmental factors that define and drive the local housing market are well evidenced and remain unchanged since the launch of the previous Housing Contribution Statements; and these also reflect the main challenges for health and social care as outlined in current strategic plans i.e. the continuing demographic trends leading to a significant decline in the local population combined with a significant growth in older persons; a fragile economic structure exacerbating affordability issues; and the dispersed rural geography which impedes service coordination and delivery. All of these factors have been exacerbated inevitably by the unprecedented impact of the coronavirus pandemic over the last two years, and the ongoing consequences are likely to have long term effects. In light of all these factors, it is worth reiterating the reciprocal and mutual benefits of joint working i.e. the important contribution that health and social care can make in turn to housing.

What we said we would do:	What we did
Housing services and associated agencies will aim to maximise the impact of available resources and tackle deprivation amongst the most vulnerable, through a range of co-ordinated activities and functions; early interventions; and supporting the retention of key workers for health and care services across all communities, by improving access to, and supply of, suitable affordable accommodation (both mainstream and specialist properties).	The Council successfully negotiated a Rural Growth Deal for Argyll & Bute which includes up to £3m investment for specific housing projects to be targeted at key & incoming workers, including HSCP staff. The HOMEArgyll partnership will be encouraged to review the Common Allocation Policy in respect of priority points awarded for appropriate “key” workers.
The SHIP programme will aim to deliver sufficient new build affordable homes to meet identified specialist needs, with a benchmark target of 10% of all completions being wheelchair accessible or alternative/bespoke models of provision. As a minimum, all new build projects should comply with Housing for Varying Needs Standards, to ensure flexibility and maximise potential adaptability within the stock, including capability for smart/assistive technology as required.	Around 225 affordable new homes were delivered via the SHIP across Argyll & Bute, including approx. 20 specialist units (wheelchair, amenity, specially adapted) since 2019/20 up to December 2021 (i.e. 9% of total completions). In addition 66 long term empty homes were brought back into effective use during 2019/20 & 2020/21.

6.3 Aligning and synchronising service delivery and needs assessments

Problems continue to arise at an operational level within both housing and health and social care when trying to co-ordinate access to suitable accommodation with the provision of appropriate support packages. Delays can occur during either part of the process, and a concerted effort to promote early intervention and better understanding of the relevant allocation and needs assessment processes is required.

What we said we would do	What we did
Establish or enhance local operational groups, with multi-agency, cross-sectoral membership, to co-ordinate responses to individual clients and shared casework on a regular basis.	Housing OT coordinates individual case reviews with area officer groups from Council and RSLs. Positive approach being replicated across all areas.
Co-ordinate awareness-raising seminars and deliver the national iHub Housing Solutions training programme to local staff across the housing, health & care sectors.	Initial round of training delivered in 2019/20 jointly by Housing OT and Council Housing Officer for range of staff throughout Argyll & Bute.
Complete an audit of existing particular needs information and advice materials and revise/update provision/services as required for targeted client groups.	This action was not progressed as scheduled, due to staff turnover constrained in-house capacity, and ongoing workloads. Housing Services to explore potential for commissioning external audit e.g. from Housing Options Scotland.
Develop and implement formal partnership agreements between individual Housing Providers/RSLs and HSCP services.	Informal partnerships have been improved, resulting in better & earlier identification of housing opportunities for HSCP clients.
Ensure HSCP engagement in the review of the common allocation policy; and in the ongoing review of waiting list applicants.	Housing OT involved in case reviews and assessment of applicants with 200 medical points; and attends HOMEArgyll Steering Group meetings.

6.4 Addressing inequalities in the delivery of adaptations

The provision of private sector adaptations is a housing function that should be delegated to the Integrated Authority while adaptations for the RSL sector currently remains separate and continues to be funded from a discrete Scottish Government fund. This can lead to inequality and result in operational confusion; and also means that funding can be constrained dependent on a household's tenure. Budget constraints for RSL adaptations remain a persistent issue, and is being closely monitored. Early notification of requirements will help to improve and streamline the process; but a national policy for a tenure-blind approach still needs to be implemented.

What we said we would do	What we did
Establish/consolidate a monitoring framework for RSL adaptations with quarterly and annual reports submitted to the Strategic Housing Forum; including a summary of Stage 3 funding allocations from the Scottish Government to individual landlords; actual spend; over/under spend at year end; and estimate of outstanding works/backlog.	The Housing OT has made initial progress in developing a framework for adaptations, and Housing Services is working to improve data collation and monitoring on Stage 3 RSL activity, investment, & waiting lists.
Explore the establishment of a joint adaptations panel for high cost/complex cases; and develop a protocol/policy for assessment and delivery of minor adaptations in the RSL sector. Complete a review of the prioritisation process for all adaptations.	Some initial work was progressed over the last 3 years via the Housing OT post, and this will be pursued over the course of this new Plan
Establish a monitoring framework for waiting times for all adaptations, and a post-completion evaluation/satisfaction protocol	As above, to be progressed & coordinated via the Housing OT
Collate data and produce a GIS map of adapted properties; and thereafter maintain this database/mapping on an annual basis	Due to staffing constraints this action has not been progressed to date. GIS mapping will be pursued over the life of the new Plan and LHS.

.

6.5 Tackling poor stock condition, fuel poverty and energy efficiency

Apart from the basic imbalances in housing supply and demand in Argyll and Bute, a key challenge for the future is to address the significant levels of disrepair and inefficient housing stock that have a major, negative impact on the health and well-being of individuals and the wider community. In general, this authority has higher than average incidence of poor condition homes and fuel poverty and this is a key priority for the new LHS and will also be an important consideration for the HSCP. Continuing to support the local Care and Repair service; providing advice and assistance to home owners, landlords and tenants; and targeting home energy programmes effectively will help to alleviate this problem. Other identified challenges include: meeting need in the private sector, particularly in the owner-occupied sector; the need to explore and expand current models of provision with more flexibility; establishing detailed assessments of need for certain vulnerable groups beyond the elderly, where data and evidence are less readily available; and meeting rural demand, for example the needs of carers supporting vulnerable people in remote locations, and ensuring sufficient support staff are available.

What we said we would do	What we did
Monitor HEEPSABS programme by household characteristics Council Housing Services will implement a monitoring framework for Energy Efficiency measures by household attribute (age, disability etc, as far as possible). This will allow assessment and evaluation of the impact of these measures specifically on those with health issues/equality groups. Reporting will be submitted to the Strategic Housing Forum.	This is currently under review and Housing Services are developing a framework for collating more detailed equalities & health related information on clients in receipt of, or applying for, grant funding for energy efficiency measures to be installed in their homes. This will be implemented early in the new Plan.
Introduce similar monitoring framework for Welfare Rights casework, in respect of age/health condition of clients who receive positive support/interventions to maximise income and tackle financial disadvantage.	Council's Welfare Rights Team are involved in the Financial Inclusion & Advice Group and currently monitor the age of clients (with particular reference to child poverty and vulnerable elderly) are aiming to enhance their monitoring framework in respect of client equalities characteristics during the life of this Plan.

7.0 Resourcing the housing contribution.

7.1 Adaptations. The provision of private sector adaptations makes a direct financial contribution to the outcomes of the health and social care partnership. Mandatory and discretionary disabled grants are funded from the council's Private Sector Housing Grant (PSHG) and administered by the Council in partnership with the Occupational Therapist Service, Third Sector, and Argyll & Bute Care & Repair. The PSHG budget for private sector adaptations (disabled grants) amounted to £764k in 2019/20; and due to the constraints on property visits by contractors and delays in the supply chain the outturn for 2020/21 was reduced to £332k. Applying one standard SROI multiplier effect per £ invested in adaptations[1] (which suggests £5.50-£6 is generated for every £1 invested) this could equate to actual investment benefits for Health & Social Care of circa £6.6m over these two years alone. On average there are around 140 private sector properties adapted annually (this average is based on pre-covid data, the figure clearly reduced over the last two years due to the constraints of the pandemic on service delivery). Future levels of PSHG are unconfirmed at this point, but the council is cautiously working on the assumption that annual budget allocations will be roughly similar to the current figure.

Adaptations for housing association properties are funded separately by the Scottish Government (known as Stage 3 funding for existing properties) and in 2019/20-2020/21 investment from this source amounted to over £1.5m, which enabled around 390 RSL homes to be adapted over that period. Based on historical allocations, it is estimated that approximately £750k will be allocated per annum over the next three years; however the Strategic Housing Forum, and the RSL sector, will continue to lobby Scottish Government for increased investment to meet the existing backlog and the projected increasing demand..

7.2 Affordable new build housing supply

The delivery of new build affordable housing is directed via the Strategic Housing Investment Plan (SHIP) and funded primarily from

- Scottish Government's Affordable Housing Supply Programme (AHSP)
- Argyll & Bute Council's Strategic Housing Fund (SHF)
- RSL private borrowing

The minimum resource planning assumptions for the AHSP in Argyll & Bute were confirmed in July 2021 as:-

Argyll & Bute	2022/23	2023/24	2024/25	3 Year Total
RPA	£18.317m	£18.264m	£18.328m	£54.909m

[1] Measuring the Social Return on Investment of Stage 3 Adaptations and Very Sheltered Housing in Scotland, Envoy Partnership (commissioned by Bield, Hanover & Trust), 2011

The current benchmark figure for grant assistance per RSL unit in remote and rural Argyll is £95,500 (with additional benchmark allowances for quality measures such as meeting energy efficiency standards; provision of balconies in flatted properties; space for home working or study; and ensuring properties are fully digitally-enabled at point of occupancy). Currently the Council provides supplementary grant assistance of £12k per new build unit and average accruals to the Strategic Housing Fund amount to around **£1.9m** per annum. All new builds are currently required to meet Houses for Varying Needs standards as a minimum, and should be suitable to meet the changing needs of individuals over time. This standard is currently under review by the Scottish Government. The 2021 SHIP currently aims to deliver around 740 new affordable homes over the three-year planning period of this HCS up to 2025, of which at least 74 (10%) should be designated as specialist provision, and within that around 37 (i.e. 5% of the SHIP total for that period) should be for purpose designed wheelchair accommodation (the actual number delivered will reflect identified needs).

7.3 Investment in existing stock

Investment in the existing housing stock to improve conditions, including energy efficiency measures, is substantial and has increased in recent years. The Scottish Government provides funding to local authorities to deliver the Energy Efficiency Programme Scotland (EEPS) which offers grant funding to households to install a range of energy efficiency measures including external wall insulation. Spend for 2019/20 was £847,060, and for 2020/21 it amounted to £391,882. Argyll and Bute secured £1,742,819 to deliver enabling and capital works in 2021/22, working primarily with partner agencies such as ALIenergy and Home Energy Scotland. It is anticipated that full spend will be achieved this year and that a similar or enhanced level of investment will be required in the coming years.

The social rented sector are required to meet national housing quality and energy efficiency standards which entails significant programmes of work and levels of investment, all of which, again, will contribute towards overarching health and social care outcomes and objectives. Over 2019/20 and 2020/21, the main HOMEArgyll RSLs in Argyll and Bute invested £9.359m in this work, bringing the majority of their existing stock up to the Energy Efficiency Standard for Social Housing (EESSH1), and will invest further over the period of this plan to achieve EESSH2..

7.4 Maximising household income

The council's Welfare Rights Team continues to liaise with the Housing Service, and is closely linked with the delivery of key objectives in the LHS and HCS; providing advice and support on welfare entitlements to vulnerable

clients across Argyll and Bute and across all tenures (albeit ACHA also provide a similar service to their own tenants). The team also provides support and advocacy for clients, including representation at HM Courts and Tribunal appeals. The team of 9 area based staff is funded primarily by the council with additional funding from Macmillan Cancer Support for an extra dedicated post. In 2019/20 and 2020/21, the team helped to support local residents to claim over **£6.35m** in benefits to which they were entitled, and it is envisaged that similar income maximisation results will be generated in future years.

7.5 Other housing functions

Additional financial investment from the housing sector, which contributes to the HSCP outcomes, includes Care & Repair budgets (also funded primarily within the PSHG) for discretionary repair and improvement work, tenancy support services (focusing on tenancy and home sustainment as opposed to personal care type support), homeless services and housing options/information and advice provision. These services will all provide positive returns for the health and social care partnership and have a preventative impact on their budgets further down the line.

7.6 Resources summary.

The key resources outlined above are summarised in the following table:

Funding Source	Housing Function	Total Investment 2022/23 – 2024/25
Affordable Housing Investment Programme (Scottish Government)	Affordable new build homes	£54.909m
Strategic Housing Fund (Argyll & Bute Council)	New build & empty homes	£5.7m (est.)
RSL Private Finance	New build homes	£33m (est.)
Private Sector Housing Grant (Argyll & Bute Council)	Private sector adaptations; Care & Repair;	£2.1m (est.)
HEEPSABS (Scottish Government)	Home energy efficiency measures	£5.2m (est.)
Stage 3 Adaptations (Scottish Government)	RSL adaptations	£2.25m (est.)
RSL EESH investment	RSL stock condition / energy efficiency improvements	tbc
Housing OT post (Argyll & Bute Council)	Permanent Post	£180k
Mental Health & Addictions Officer post (Argyll & Bute Council RRTP funding)	Temp post until March 2024	£120k (for 2 financial years)
Welfare Rights Assistance, Advice & Support	Maximising household income	£8m (est.)

8.0 Conclusion

The fundamental principles outlined in the previous Housing Contribution Statement are still valid and relevant, looking forward over the next three years. The integration agenda presents potential opportunities to maximise effective joint working particularly to apply housing resources directly and indirectly to prevent costly health and care interventions at a later date. Conversely, the cost benefits of a reciprocal Health Contribution to support housing sector activity would also be mutually beneficial for all partners. This will require focused, on-going dialogue between the Strategic Housing Forum, individual organisations and the HSCP, with a view to forging even closer linkages between the LHS, SHIP and the Strategic Commissioning Plan. As part of the formal monitoring and review process for the LHS, specific outcomes, milestones, timescales, indicators and targets in respect of housing's contribution to health and social care will be subject to

- Appraisal by Scottish Government/peer review via Scottish Housing Network
- Scrutiny by the Scottish Housing Regulator
- Regular progress reporting, including annual updates, to the Strategic Housing Forum, Elected Members, individual organisation boards, community planning partners and groups, and general stakeholders
- Formal reports on specific outcomes to wider thematic partnerships (e.g. economic fora) including the HSCP on a regular basis.

The ethos and principles of the Housing Sector are clearly already aligned with that of the HSCP, with a strong focus on preventative policies, home and person-centred services, a holistic approach to strategic planning, a fundamental commitment to reducing and eradicating inequalities, and pursuing efficiency and cost effectiveness.

In summary, this contribution statement has highlighted the key role that the housing sector will have in joint planning, commissioning and delivery of services as well as influencing investment decisions to support the Strategic Plan's outcomes and objectives. There are crucial links between:

- the LHS and the Strategic Plan;
- the HNDA and JSNA;
- homelessness, tenancy support, fuel poverty, energy efficiency and adaptations services and the strategic plan and HSCP services; and
- the Strategic Housing Forum & the HSCP/Integration Authority structures.

The Housing Sector in Argyll and Bute continues to welcome this opportunity to strengthen these connections and to improve the alignment of strategic planning; focusing on common outcomes, with a view to prevention; increased supply of

suitable housing options; and, in addition, to support and promote partnership and community capacity building.

JSNA AND POPULATION PROFILE REFERENCES

[1] National Records of Scotland, “Mid-2016 Settlements and Localities,” [Online]. Available: https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-estimates/settlements-and-localities.

[2] Argyll and Bute HSCP, “Joint Strategic Needs Assessment 2019,”. Available: Available through request.

[3] Argyll and Bute HSCP, “Joint Strategic Needs Assessment - Children and Young people Desk-based data review August 2020,”. Available: Available through request.

[4] NHS Highland Annual Report of the Director of Public Health 2019, “Past, Present and Future Trends in Health and Wellbeing,” [Online]. Available: https://www.nhshighland.scot.nhs.uk/Publications/Documents/DPH-Annual-Report-2019-and-appendices.pdf.

[5] Public Health Scotland, “HSCP Locality profiles,” Appendicies 5-12

[6] Argyll and Bute HSCP, “Evidence of the impact of COVID-19 in Argyll and Bute December 2020,” [Online]. Available: Available through request.

[7] National Records of Scotland, “Mid-Year Population Estimates,” [Online]. Available: https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-estimates/mid-year-population-estimates.

[8] National Records of Scotland, “Projected Population of Scotland (2018-based),” [Online]. Available: https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-projections/population-projections-scotland/2018-based.

[9] Scottish Government, “Scottish Government Urban Rural Classification 2016,” [Online]. Available: https://www.gov.scot/publications/scottish-government-urban-rural-classification-2016/pages/0/.

[10] Scottish Government, “Scottish Index of Multiple Deprivation 2020,” [Online]. Available: https://www.gov.scot/collections/scottish-index-of-multiple-deprivation-2020/.

[11] National Records of Scotland, “Inhabited islands analytical report,” [Online]. Available: https://www.scotlandscensus.gov.uk/documents/inhabited-islands-analytical-report/.

[12] NHS Highland Annual Report of the Director of Public Health 2018, “Adverse Childhood Experiences, Resilience and Trauma Informed Care: A Public Health Approach to Understanding and Responding to Adversity,” [Online]. Available:

https://www.nhshighland.scot.nhs.uk/Publications/Documents/DPH-Annual-Report-2018_(web-version).pdf.

[13] NHS Highland Annual Report of the Direcor of Public Health 2020, “Coronavirus (COVID-19) in the NHS Higland area,” [Online]. Available: https://indd.adobe.com/view/53d8d221-7734-4136-b535-c192a14e36c9.

[14] Scottish Government, “Scottish Health Survey 2019 - volume 1: main report. Chapter 8: Adverse Childhood Experiences,” [Online]. Available: https://www.gov.scot/publications/scottish-health-survey-2019-volume-1-main-report/pages/11/.

[15] Argyll and Bute Council, “Information about Argyll and Bute,” [Online]. Available: https://www.argyll-bute.gov.uk/info/home.

[16] Scottish Government, “Rural deprivation: an evidence review,” [Online]. Available: https://www.gov.scot/publications/scottish-index-of-multiple-deprivation-rural-deprivation-evidence-review-and-case-studies/.

[17] Public Health Scotland, “Child poverty overview,” [Online]. Available: http://www.healthscotland.scot/population-groups/children/child-poverty/child-poverty-overview/causes-of-child-poverty.

[18] Department for Work and Pensions, “Children in low income families: local area statistics,” [Online]. Available: https://www.gov.uk/government/collections/children-in-low-income-families-local-area-statistics.

[19] Highlands and Islands Enterprise, “A Minimum Income Standard for Remote Rural Scotland 2016,” [Online]. Available: https://www.hie.co.uk/research-and-reports/our-reports/2016/november/30/a-minimum-income-standard-for-remote-rural-scotland-a-policy-update/.

[20] Scottish Government, “Scottish House Condition Survey: Local Authority Analysis 2017-2019 Fuel Poverty,” [Online]. Available: https://www.gov.scot/publications/scottish-house-condition-survey-local-authority-analysis-2017-2019/pages/6/.

[21] Scottish Government, “Children's social work statistics: 2019 to 2020,” [Online]. Available: https://www.gov.scot/publications/childrens-social-work-statistics-2019-20/documents/.

[22] Scottish Children's Reporter Administration, “Official Statistics,” [Online]. Available: https://www.scra.gov.uk/resources_articles_category/official-statistics/.

[23] Scottish Public Health Observatory, “Online Profiles Tool,” [Online]. Available: https://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool/.

[24] Public Health Scotland, “Insights in social care: statistics for Scotland. Support provided or funded by health and social care partnerships in Scotland 2018/19,” [Online]. Available: https://www.publichealthscotland.scot/publications/insights-in-social-care-statistics-for-

scotland/insights-in-social-care-statistics-for-scotland-support-provided-or-funded-by-health-and-social-care-partnerships-in-scotland-201819/.

[25] Argyll and Bute Council and Argyll and Bute HSCP, “Health and Care and Housing Needs Assessment,” [Online]. Available: https://www.argyll-bute.gov.uk/sites/default/files/housing_and_health_and_care_needs_-_july_2018.pdf.

[26] Argyll and Bute Council, “Local Housing Strategy and Housing Need and Demand Assessment,” [Online]. Available: https://www.argyll-bute.gov.uk/housing/housing-strategies-consultations-and-research-0.

[27] National Records of Scotland, “Winter Mortality in Scotland 2020/21,” [Online]. Available: https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/winter-mortality/winter-mortality-in-scotland-202021.

[28] Scottish Government, “Scotland's Carers,” [Online]. Available: https://www.gov.scot/publications/scotlands-carers/.

[29] SPICe , “Climate Change and Health in Scotland,” [Online]. Available: http://archive2021.parliament.scot/ResearchBriefingsAndFactsheets/S4/SB_12-26rev.pdf.

[30] UK HEalth Security Agenga, “Understanding the health effects of climate change,” [Online]. Available: https://ukhsa.blog.gov.uk/2021/11/09/understanding-the-health-effects-of-climate-change/.

[31] HM Government, “UK Climate Change Risk Assessment 2022,” [Online]. Available: https://www.gov.uk/government/publications/uk-climate-change-risk-assessment-2022.

[32] Scottish Government, “NHS Scotland climate emergency and sustainability strategy 2022 to 2026 - draft: consultation,” [Online]. Available: https://www.gov.scot/publications/nhs-scotland-draft-climate-emergency-sustainability-strategy/pages/1/.

[33] National Records of Scotland, “Life Expectancy in Scotland, 2018-2020,” [Online]. Available: https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/life-expectancy/life-expectancy-in-scotland/2018-2020.

[34] Scottish Public Health Observatory, “Recent mortality trends,” [Online]. Available: https://www.scotpho.org.uk/population-dynamics/recent-mortality-trends/.

[35] Public Health Scotland, “What are health inequalities?,” [Online]. Available: http://www.healthscotland.scot/health-inequalities/what-are-health-inequalities.

[36] Scottish Government, “Scottish Surveys Core Questions 2019,” [Online]. Available: https://www.gov.scot/publications/scottish-surveys-core-questions-2019/.

[37] Scottish Government, “Disability - Scottish Surveys Core Questions,” [Online]. Available: https://statistics.gov.scot/resource?uri=http%3A%2F%2Fstatistics.gov.scot%2Fdata%2Fdisability-

sscq.

[38] Scottish public Health Observatory, “Local area burden of disease,” [Online]. Available: https://www.scotpho.org.uk/comparative-health/burden-of-disease/local-area-burden-of-disease/.

[39] Scottish Commission for People with Learning Disabilities, “2019 Report,” [Online]. Available: https://www.scld.org.uk/2019-report/.

[40] Public Health Scotland, “All releases of Unintentional injuries,” [Online]. Available: https://www.publichealthscotland.scot/publications/show-all-releases?id=20525.

[41] NHS Highland Annual Report of the Director of Public Health 2021, “Suicide and Mental Health,” [Online]. Available: https://indd.adobe.com/view/ac44f0a2-34cf-46e5-8865-e165211866c7.

[42] Scottish Government, “Smoking - Scottish Survey Core Questions,” [Online]. Available: https://statistics.gov.scot/resource?uri=http%3A%2F%2Fstatistics.gov.scot%2Fdata%2Fsmoking-sscq.

[43] Scottish Government, “Scottish Health Survey-Local area level data,” [Online]. Available: https://statistics.gov.scot/resource?uri=http%3A%2F%2Fstatistics.gov.scot%2Fdata%2Fscottish-health-survey-local-area-level-data.

[44] Public Health Scotland, “Teenage pregnancies Year of conception, ending 31 December 2019,” [Online]. Available: https://publichealthscotland.scot/publications/teenage-pregnancies/teenage-pregnancies-year-of-conception-ending-31-december-2019/.

[45] Health Protection Scotland, “Sexually transmitted infection,” [Online]. Available: https://www.hps.scot.nhs.uk/a-to-z-of-topics/sexually-transmitted-infection/.

[46] Scottish Public Health Observatory, “Sexual health: key points,” [Online]. Available: https://www.scotpho.org.uk/behaviour/sexual-health/key-points/.

[47] Scottish public Health Observatory, “Suicide: key points,” [Online]. Available: https://www.scotpho.org.uk/health-wellbeing-and-disease/suicide/key-points/.

[48] Scottish Government, “COVID-19 in Scotland,” [Online]. Available: https://data.gov.scot/coronavirus-covid-19/index.html.

[49] Public Health Scotland, “COVID-19 wider impacts on the health care system,” [Online]. Available: https://scotland.shinyapps.io/phs-covid-wider-impact/.

[50] Scottish Government, “Coronavirus (COVID-19): modelling the epidemic (issue no.90),” [Online]. Available: https://www.gov.scot/publications/coronavirus-covid-19-modelling-epidemic-issue-no-90/.

[51] National Records of Scotland, “Deaths involving coronavirus (COVID-19) in Scotland 2022 Week

6," [Online]. Available: https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/general-publications/weekly-and-monthly-data-on-births-and-deaths/deaths-involving-coronavirus-covid-19-in-scotland/archive.

[52] Public Health Scotland, "Daily COVID-19 Cases in Scotland," [Online]. Available: https://www.opendata.nhs.scot/dataset/covid-19-in-scotland.

[53] Scottish Public health Observatory, "COVID-19 Wider Impacts," [Online]. Available: https://www.scotpho.org.uk/comparative-health/coronavirus-covid-19/covid-19-wider-impacts/.

[54] Public Health Scotland, "NHS waiting times - stage of treatment," [Online]. Available: https://www.publichealthscotland.scot/publications/nhs-waiting-times-stage-of-treatment/stage-of-treatment-waiting-times-inpatients-day-cases-and-new-outpatients-22-february-2022/.

[55] National records of Scotland, "Scotland's Population 2019 The Registrar General's Annual Review of Demographic Trends," [Online]. Available: https://www.nrscotland.gov.uk/files//statistics/rgar/2019/Pages/key-messages.html.

[56] Public Health Scotland, "Underlying causes of excess deaths in Scotland during the COVID-19 pandemic, by area deprivation 26 August 2020," [Online]. Available: https://publichealthscotland.scot/media/7186/non-covid-19_excess_deaths_by_cause-report.pdf.

[57] National Records of Scotland, "Deaths involving coronavirus (COVID-19) in Scotland," [Online]. Available: https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/general-publications/weekly-and-monthly-data-on-births-and-deaths/deaths-involving-coronavirus-covid-19-in-scotland.

[58] Public Health Scotland, "COVID-19 Early Years Resilience and Impact Survey (CEYRIS)," [Online]. Available: https://www.publichealthscotland.scot/our-areas-of-work/covid-19/covid-19-data-and-intelligence/covid-19-and-children-research/covid-19-early-years-resilience-and-impact-survey-ceyris/.

[59] Scottish Women's Aid, "Crisis and Resilience: the impact of a global pandemic on domestic abuse survivors and service providers in Scotland," [Online]. Available: https://womensaid.scot/wp-content/uploads/2020/09/SWA-COVID-Report.pdf.

[60] Scottish Government, "cottish Welfare Fund, Self-Isolation Support Grant and Discretionary Housing Payments: monthly data," [Online]. Available: https://www.gov.scot/publications/swf-monthly-management-information/.

[61] Scottish Government, "Coronavirus (COVID-19): mental health - transition and recovery plan," [Online]. Available: https://www.gov.scot/publications/mental-health-scotlands-transition-recovery/pages/1/.

[62] Public Health Scotland, “Rapid international evidence review: Impact of the COVID-19 disease control measures on physical activity and dietary behaviours and weight,” [Online]. Available: https://www.publichealthscotland.scot/media/2844/impact-of-the-covid-19-disease-control-measures-on-physical-activity-and-dietary-behaviours-and-weight-oct2020-english.pdf.

[63] Crew, “COVID-19 AND DRUGS – OTHER SURVEYS,” [Online]. Available: https://www.crew.scot/covid-19-other-surveys/.

[64] Public Health Scotland, “COVID-19 Shielding Programme (Scotland) Impact and Experience Survey September 2020,” [Online]. Available: https://www.publichealthscotland.scot/media/2763/covid-19-shielding-programme-scotland-impact-and-experience-survey_sept2020_english.pdf.

[65] Age UK, “Age UK research lays bare the drastic impact of the pandemic on our older population’s health and morale,” [Online]. Available: https://www.ageuk.org.uk/latest-press/articles/2020/10/age-uk--research-into-the-effects-of-the-pandemic-on-the-older-populations-health/.

[66] Carers UK, “Unseen and undervalued: The value of unpaid care provided to date during the COVID-19 pandemic,” [Online]. Available: https://www.carersuk.org/for-professionals/policy/policy-library/unseen-and-undervalued-the-value-of-unpaid-care-provided-to-date-during-the-covid-19-pandemic.

[67] Iriss, “Covid-19, low incomes and poverty,” [Online]. Available: https://www.iriss.org.uk/resources/esss-outlines/covid-19-low-incomes-and-poverty.

Public Health Scotland

HSCP Profile 2020/21

Argyll and Bute

December 2021

Table of Contents

Notes for this profile:

- All years shown are calendar years unless otherwise specified.
- Upper and lower 95% confidence intervals are shown throughout this document where available. In charts, these are displayed as shaded areas either side of trend lines, or as black error bars in bar charts. Confidence intervals show the range of possible values and a certainty that the true value falls within them.
- Definitions for the indicators shown are available in the Appendices of the accompanying summary document.
- Any zero figures for some indicators will indicate either suppression of small data or a complete lack of data available for this health and social care partnership (HSCP)
- Data should be interpreted with caution, particularly for areas with relatively small population sizes where indicator data is expected, by chance alone, to have higher variation than in areas of larger population size. Note that differences between areas can relate to multiple factors including, for example, underlying rates of illness, rates of diagnosis and local differences in practice e.g. in data recording.

Demographics

Summary:

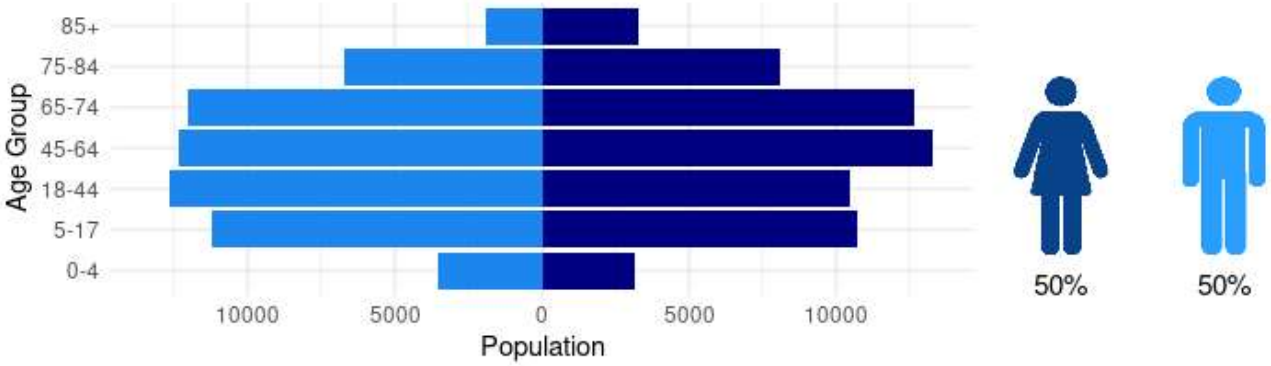
For the most recent time periods available, Argyll and Bute HSCP had:

- A total population of **85,430** people, where **50%** were male, and **26%** were aged over 65.
- **11%** of people lived in the least deprived SIMD quintile, and **8.7%** lived in the most deprived quintile.

Population

In 2020, the total population of Argyll and Bute HSCP was **85,430**. The graph below shows the population distribution of the HSCP.

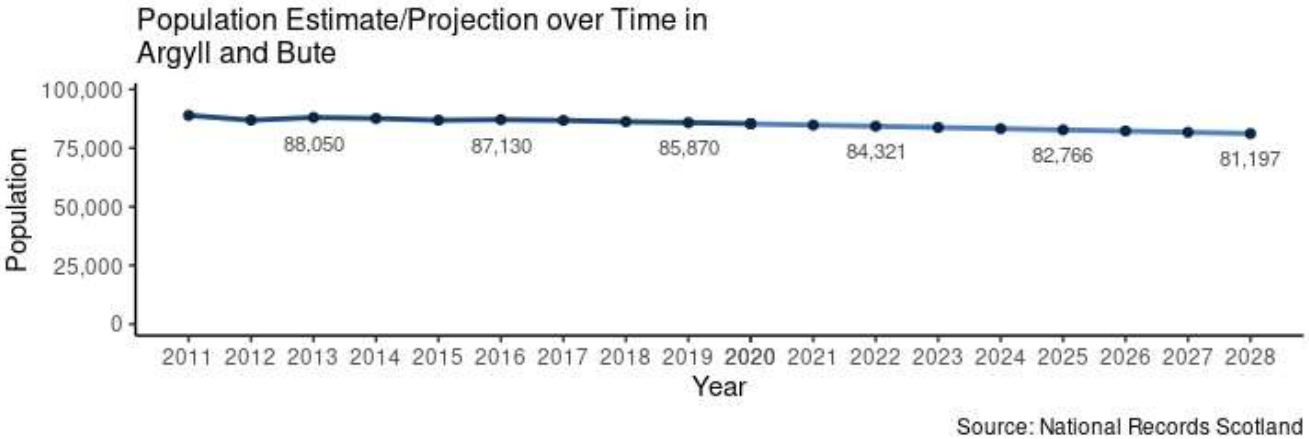
Figure 1: Population breakdown in Argyll and Bute.



Source: National Records Scotland

Figure 2 shows the historical population of Argyll and Bute, along with the NRS population projections. The population has been falling. The population in Argyll and Bute is estimated to decrease by 3% from 2020 to 2025.

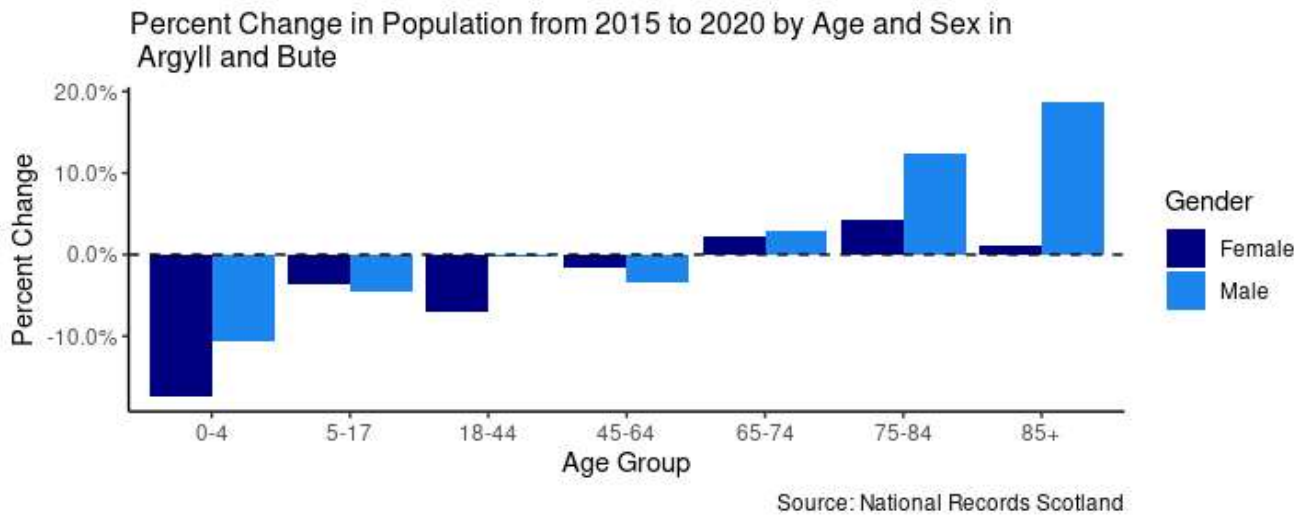
Figure 2: Population time trend and projection.



Source: National Records Scotland

Figure 3 shows how population structure has changed between 2015 and 2020.

Figure 3: Change in population structure over the last five years.



Deprivation

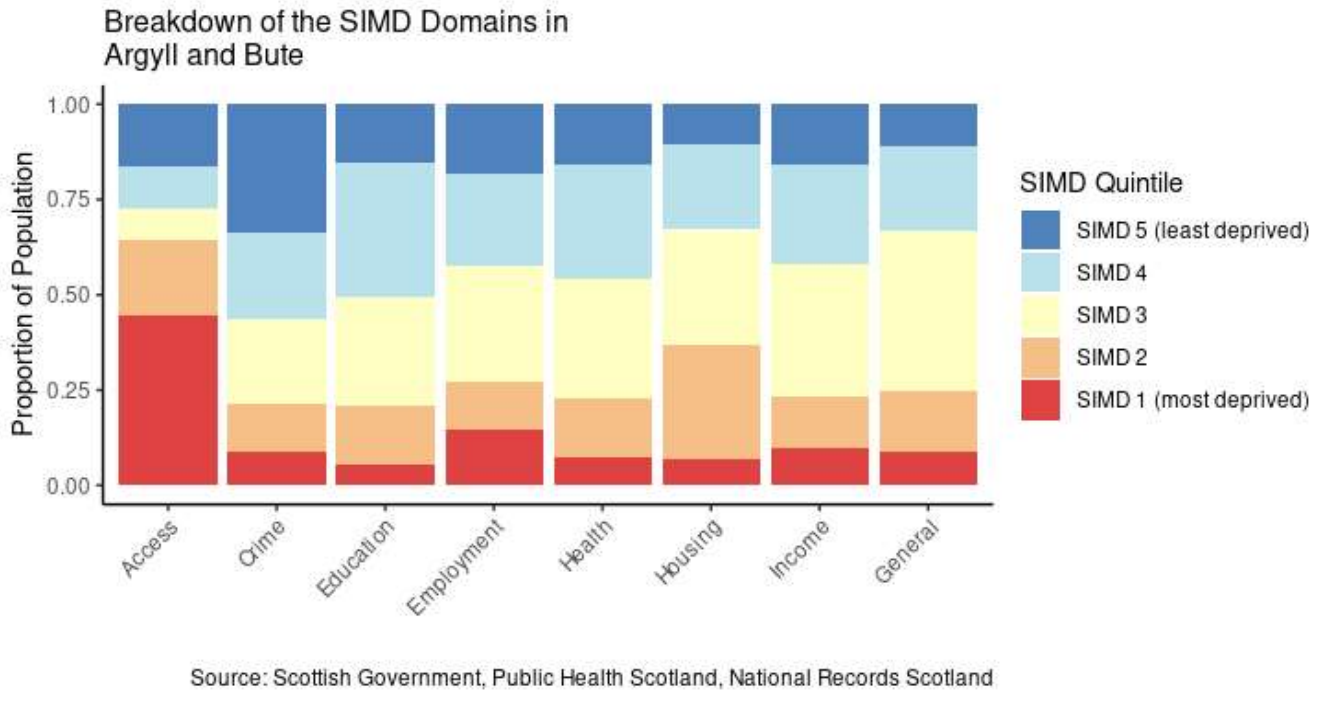
The following section explores the deprivation structure of Argyll and Bute through the Scottish Index of Multiple Deprivation (SIMD). The SIMD ranks all datazones in Scotland by a number of factors; Access, Crime, Education, Employment, Health, Housing and Income. Based on these ranks, each datazone is then given an overall deprivation rank, which is used to split datazones into Deprivation Quintiles (Quintile 1 being the most deprived, and Quintile 5 the least). The most recent SIMD ranking was carried out in 2020. This section mainly focuses on the SIMD 2020 classifications, however the 2016 classifications are used to assess how deprivation has changed in Argyll and Bute when compared to the rest of Scotland.

Of the 2020 population in Argyll and Bute, **8.7%** live in the most deprived SIMD Quintile, and **11%** live in the least deprived SIMD Quintile. The following table details the percent of the population living in the 2016 SIMD Quintiles, the percent living in the 2020 SIMD Quintiles, and their difference for comparison.

Table 1: Percentage population living in the 2016 and 2020 SIMD Datazone Quintiles

Quintile	Percent of Pop (2016)	Percent of Pop (2020)	Difference
SIMD 1	7.5%	8.7%	1.1%
SIMD 2	17.1%	16.0%	-1.0%
SIMD 3	41.1%	41.9%	0.8%
SIMD 4	24.4%	22.6%	-1.8%
SIMD 5	9.9%	10.8%	0.9%

Figure 4: Proportion of the population that reside in each 2020 SIMD quintile by domain.



Source: Scottish Government, Public Health Scotland, National Records Scotland

Households

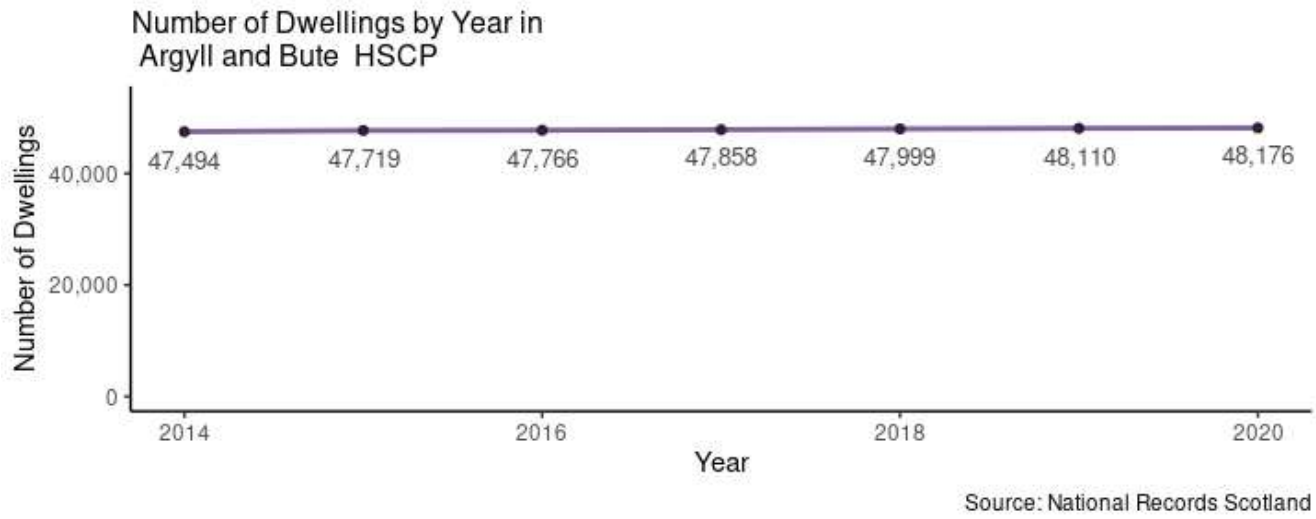
Summary:

For the most recent time periods available, Argyll and Bute HSCP had:

- **48,176** dwellings, of which: **89%** were occupied and **6.5%** were second homes.
- **33%** of dwellers received a single occupant council tax discount, and **2.5%** were exempt from council tax entirely.
- **56%** of houses were within council tax bands A to C, and **16%** were in bands F to H.

The graph below shows the number of dwellings in Argyll and Bute from 2014 to 2020.

Figure 5: Number of dwellings time trend.



Of the total number of dwellings in 2020, 33% (15,773 households) were occupied by an individual receiving a single occupant council tax discount. Furthermore, 2.5% (1,216 households) were occupied and exempt from council tax.

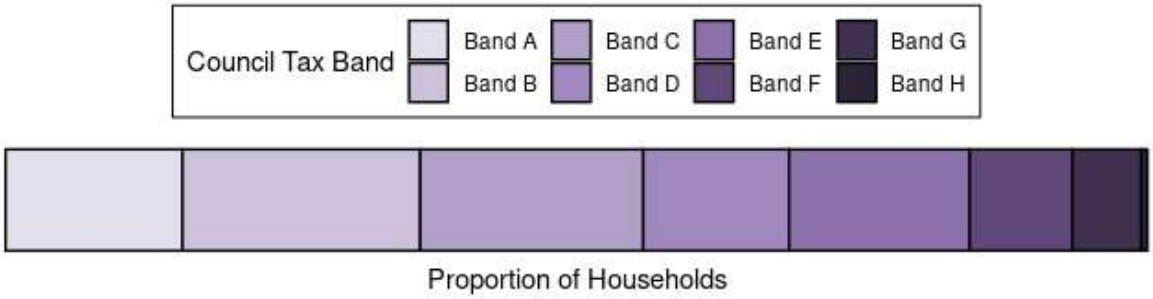
There were 3,123 dwellings classed as a second home in 2020, these dwellings made up 6.5% of the households in Argyll and Bute.

Table 2: Breakdown of dwelling types by year for Argyll and Bute HSCP.

Year	Total Dwellings	Occupied Dwellings	Vacant Dwellings	Single Occupant Tax Discount	Council Tax Exempt Dwellings	Second Homes
2014	47,494	41,764	2,350	15,509	1,197	3,378
2015	47,719	41,918	2,373	15,271	1,211	3,428
2016	47,766	42,007	2,367	15,384	1,215	3,391
2017	47,858	42,499	2,104	15,381	1,199	3,252
2018	47,999	42,604	2,175	15,318	1,245	3,219
2019	48,110	42,784	2,199	15,408	1,297	3,127
2020	48,176	42,819	2,239	15,773	1,216	3,123

The proportion of households within each council tax band are displayed in the chart below, figures are shown in Table 3.

Figure 6: Breakdown of households by council tax band for Argyll and Bute in 2020.



Source: National Records Scotland

Table 3: Percentage of households by council tax band for Argyll and Bute in 2020.

Tax Band	A	B	C	D	E	F	G	H
Percent of households	15%	21%	20%	13%	16%	9%	6.1%	0.53%

General Health

Summary:

For the most recent time periods available[1], Argyll and Bute HSCP had:

- An average life expectancy of **78** years for males and **81.6** years for females.
- A death rate for ages 15 to 44 of **106** deaths per 100,000 age-sex standardised population[2]
- **24%** of the HSCPs population with at least one long-term physical health condition.
- A cancer registration rate of **609** registrations per 100,000 age-sex standardised population[4]
- **19.12%** of the population being prescribed medication for anxiety, depression, or psychosis.

Life Expectancy

In the latest time period available from 2018-2020 (3 year aggregate), the average life expectancy in Argyll and Bute HSCP was 78 years old for men, and 81.6 years old for women. A time trend since 2014-2016 can be seen in figure 8.

Figure 8: Average life expectancy in men and women over time.

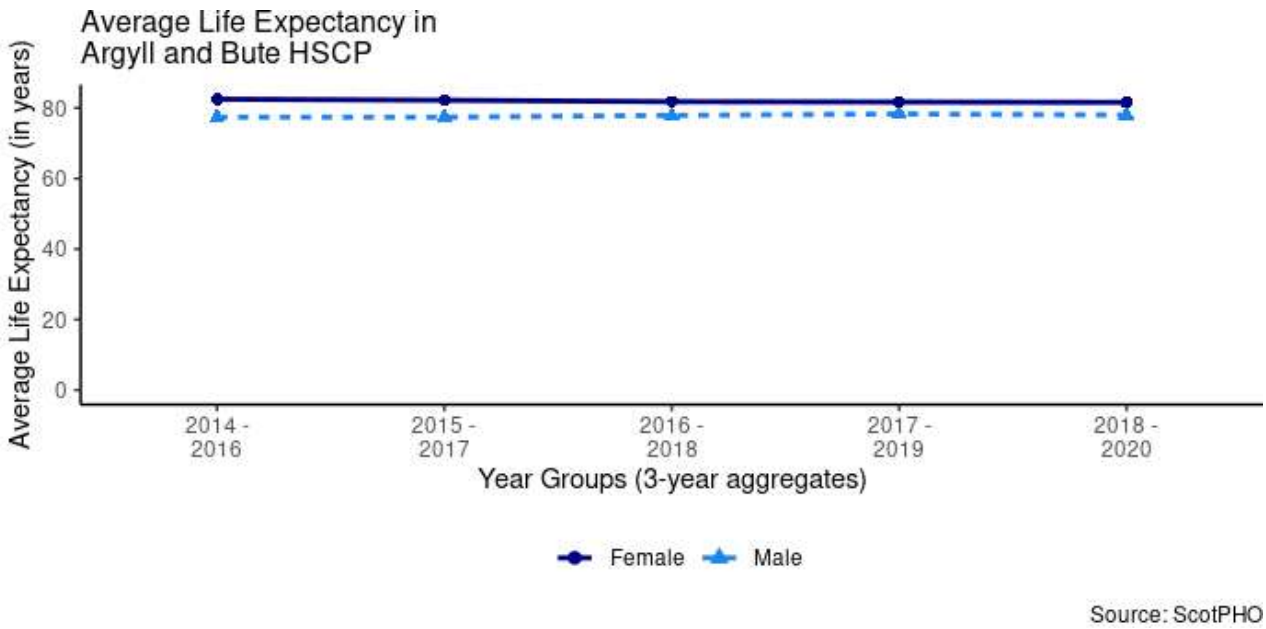


Table 5 provides the average life expectancy for men and women in different areas for the latest time period available.

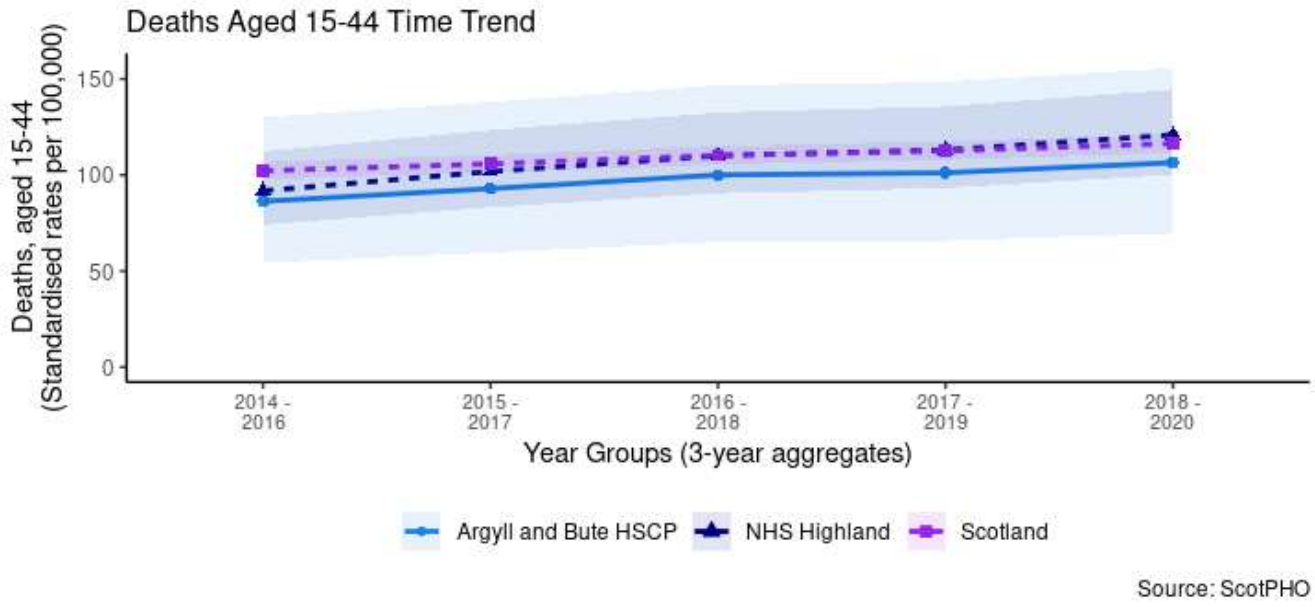
Table 5: Average life expectancy in years for the latest time periods

	Partnership	Health Board	Scotland
	81.6	81.8	81
	78	77.6	76.8

Deaths, aged 15-44

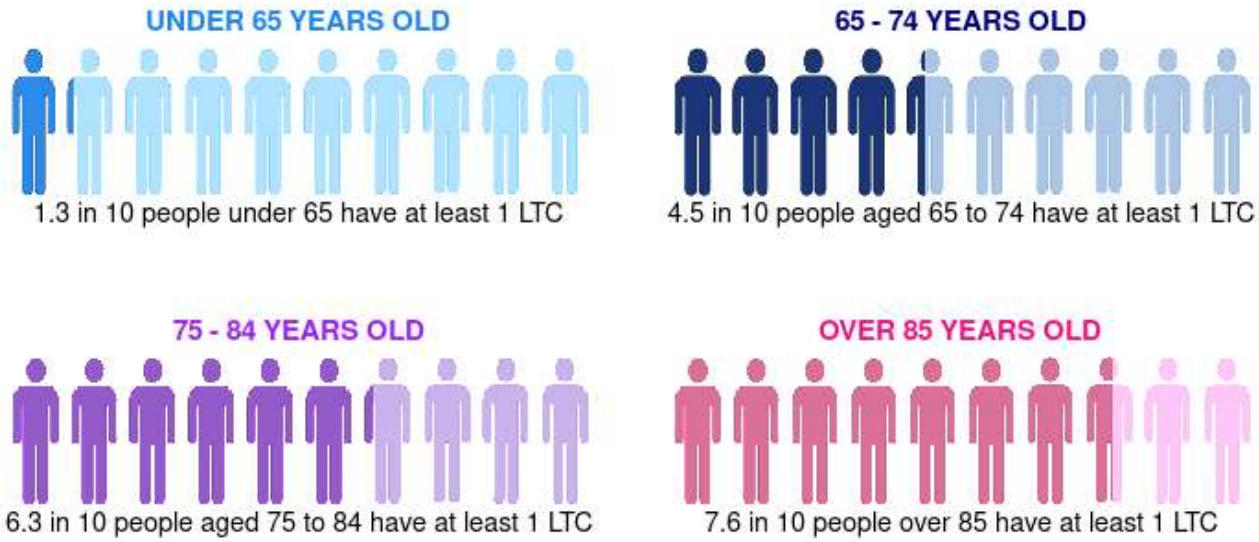
The following chart shows a trend of death rates among 15-44 year olds per 100,000 age-sex standardised population[2] by area (i.e. early mortality rate per 100,000). In the most recent aggregate time period available (from 2018-2020), the mortality rate in Argyll and Bute HSCP was **106** deaths per 100,000 population.

Figure 9: Deaths aged 15-44 years by geographical area and over time.



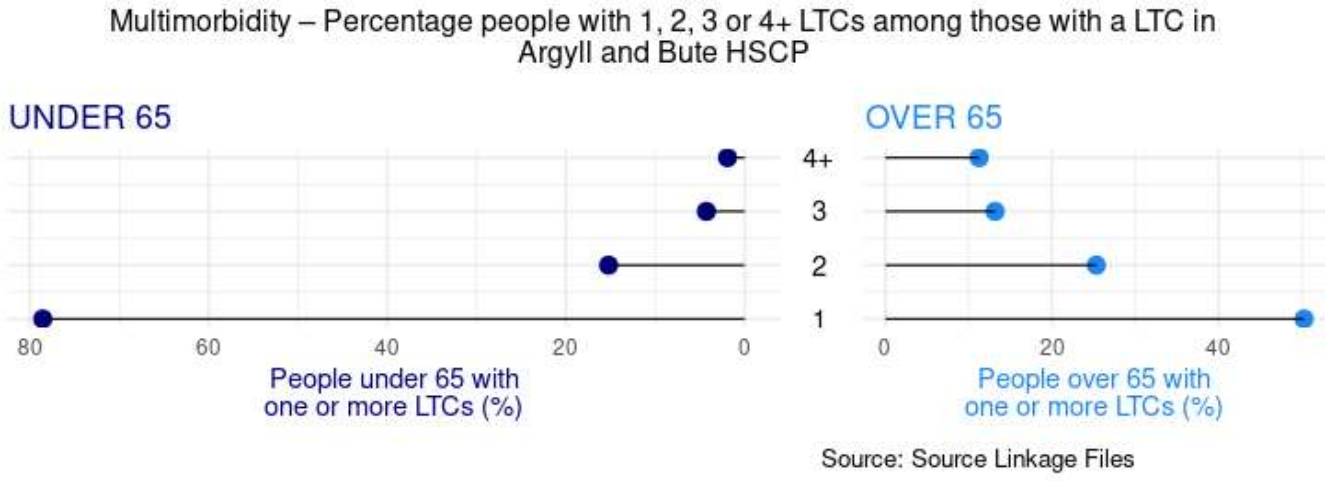
Long-Term Physical Health Conditions and Multimorbidity

In the financial year 2020/21, in Argyll and Bute HSCP, **24%** of the total population had at least one physical long-term condition (LTC). These include: cardiovascular, neurodegenerative, and respiratory conditions, as well as other organ conditions (namely liver disease and renal failure), arthritis, cancer, diabetes, and epilepsy. *Please see footnotes for information and caveats on identifying LTCs.*[3]



The co-occurrence of two or more conditions, known as multimorbidity, is broken down in figure 12, distinguishing between age groups. Note that this chart *excludes* the population in the HSCP who do not have any physical long-term conditions. Figure 12 therefore shows that among the people who have a LTC, **21**% of those under the age of 65 have more than one, compared to **50**% of those aged over 65.

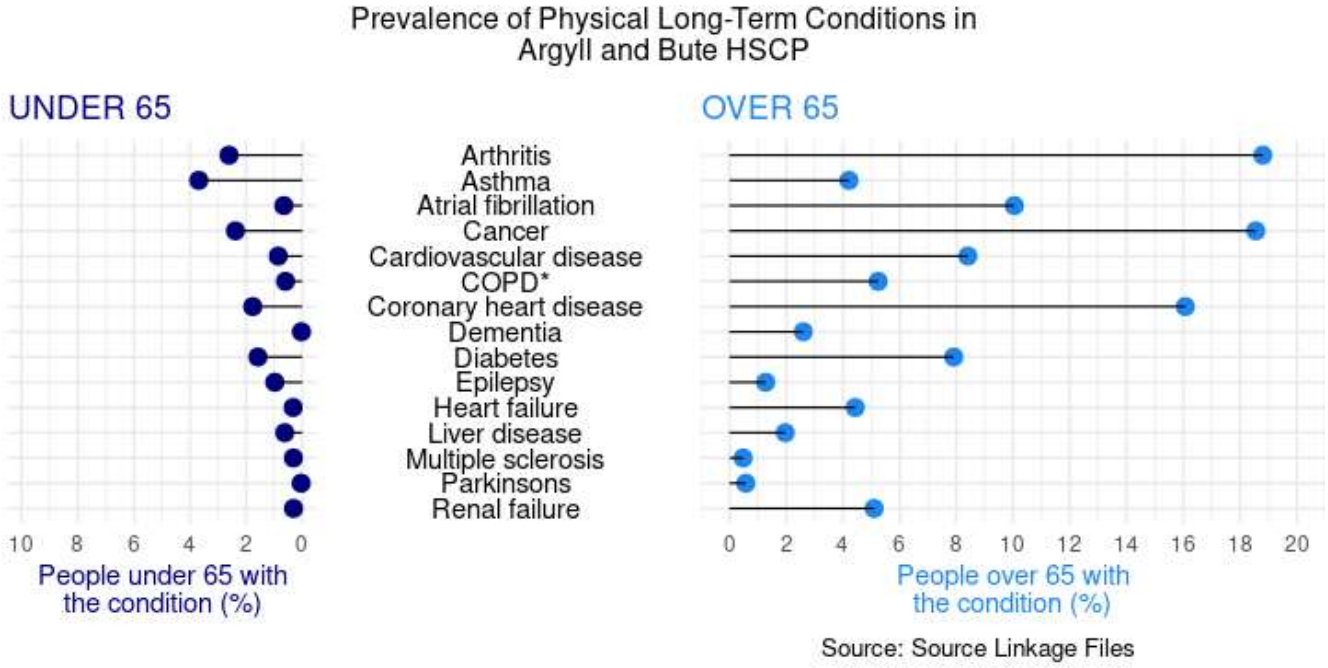
Figure 10: Multimorbidity of physical long-term conditions by age group in 2020/21.



Most common physical Long-Term Conditions (LTCs)

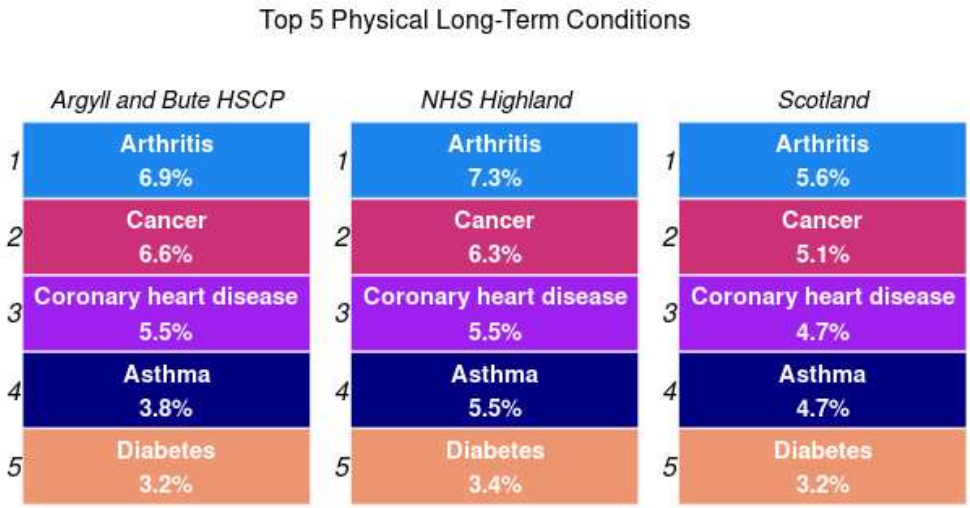
Below is a breakdown of the physical LTCs, for the financial year 2020/21. Figure 13 shows the prevalence of different LTCs in each age group in Argyll and Bute HSCP, and Table 6 illustrates the top 5 physical LTCs across all ages at Partnership, Health Board and Scotland level.

Figure 11: Percentage people with each physical LTC, split by age group.



**COPD: Chronic Obstructive Pulmonary Disease*

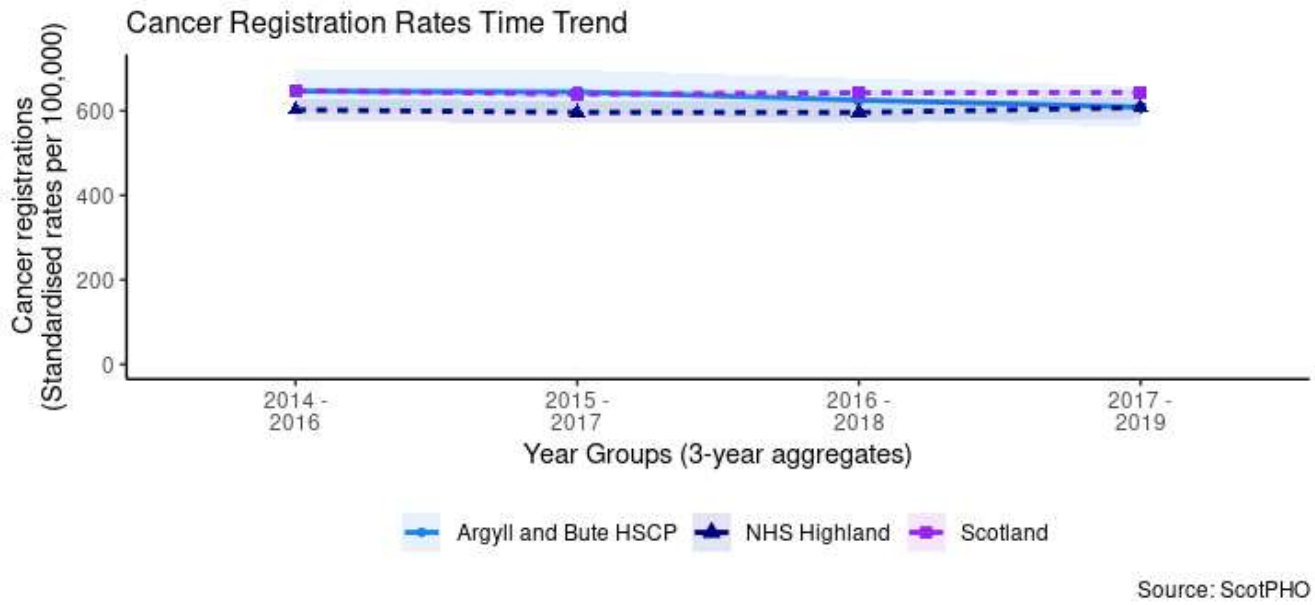
Table 6: Prevalence of the five most common physical LTCs as a percentage of the population across geographical areas (where 1 = most prevalent).



Cancer Registrations

For the period 2017-2019, there were 638 new cancer registrations per year on average (**609** registrations per 100,000 age-sex standardised population) in Argyll and Bute HSCP. This is a **2.7%** decrease in cancer registrations rate from the previous aggregate period 2016-2018. Figure 12 shows changes over time since 2014-2016.

Figure 12: Cancer registration rate over time and by geographical area.



Anxiety, Depression, and Psychosis Prescriptions

In the 2019/20 financial year, 19.12% of people were prescribed medication for anxiety, depression, or psychosis (ADP) in Argyll and Bute HSCP. This is a 2.8% increase from the previous financial year. Differences over time and between areas may relate to multiple factors, only one of which is underlying disease. Note that data are based on main original licensed use for the prescriptions and some drugs included may be prescribed for other purposes.

Figure 13: Percentage population prescribed ADP medication in Argyll and Bute HSCP.

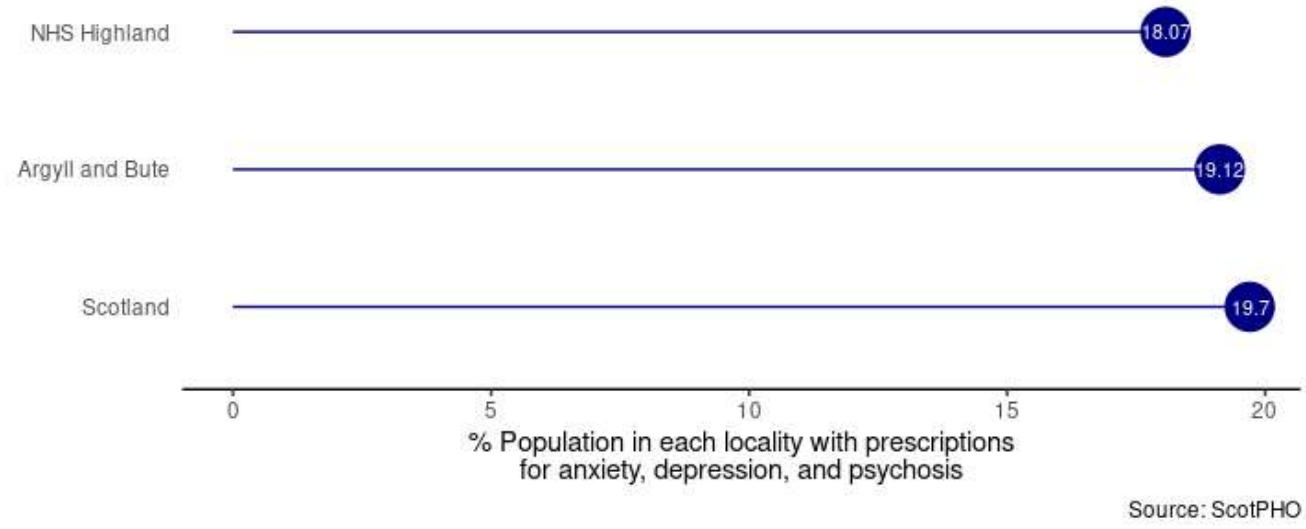
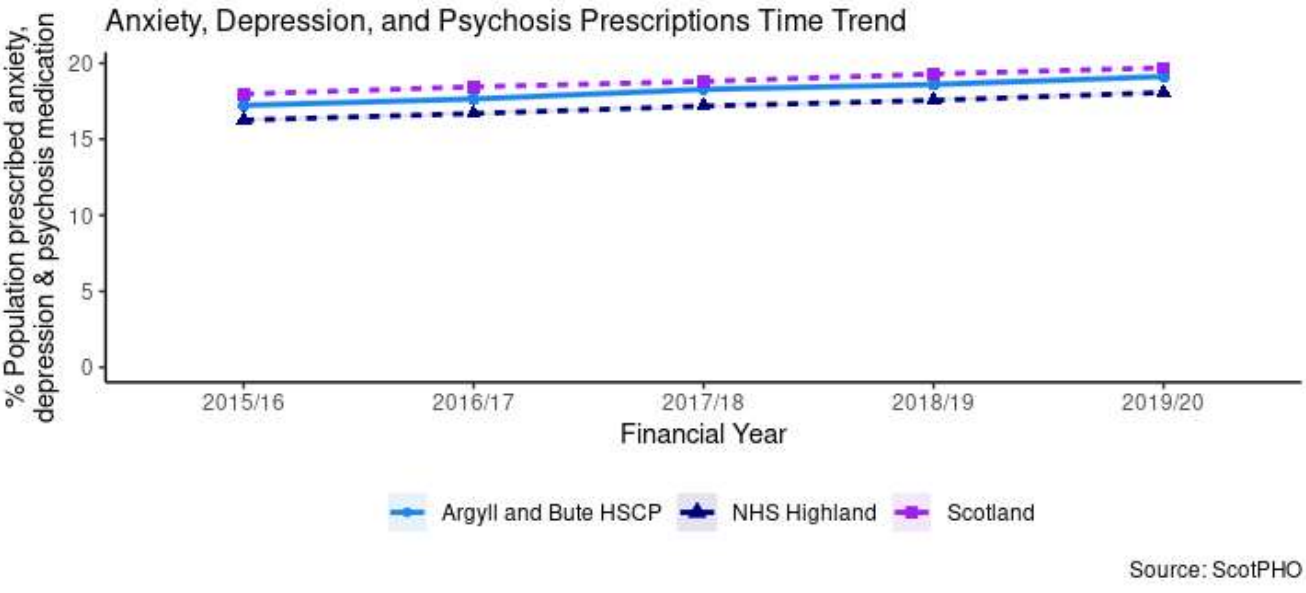


Figure 14: ADP prescriptions over time and by geographical area.



Behavioural Factors

Summary:

Mental and physical wellbeing has close ties with people's behaviours. Life circumstances including financial security, employment and location are interlinked with behavioural factors. This section provides data on drug-related hospital admissions, alcohol-related hospital admissions, alcohol-specific mortalities and bowel screening uptake, to give an overview of some behaviours known to be associated with health and wellbeing outcomes.

For the most recent time periods available[1], Argyll and Bute had:

- **124** drug-related hospital admissions per 100,000 age-sex standardised population[2]. This is a lower rate of admissions than for Scotland (221).
- **22** drug-specific mortalities per 100,000 age-sex standardised population[2]. This is a lower rate than for Scotland (25.44).
- **638** alcohol-related hospital admissions per 100,000 age-sex standardised population[2].
- **20** alcohol-specific mortalities per 100,000 age-sex standardised population[2].
- a **64%** uptake of bowel cancer screening for the eligible population.

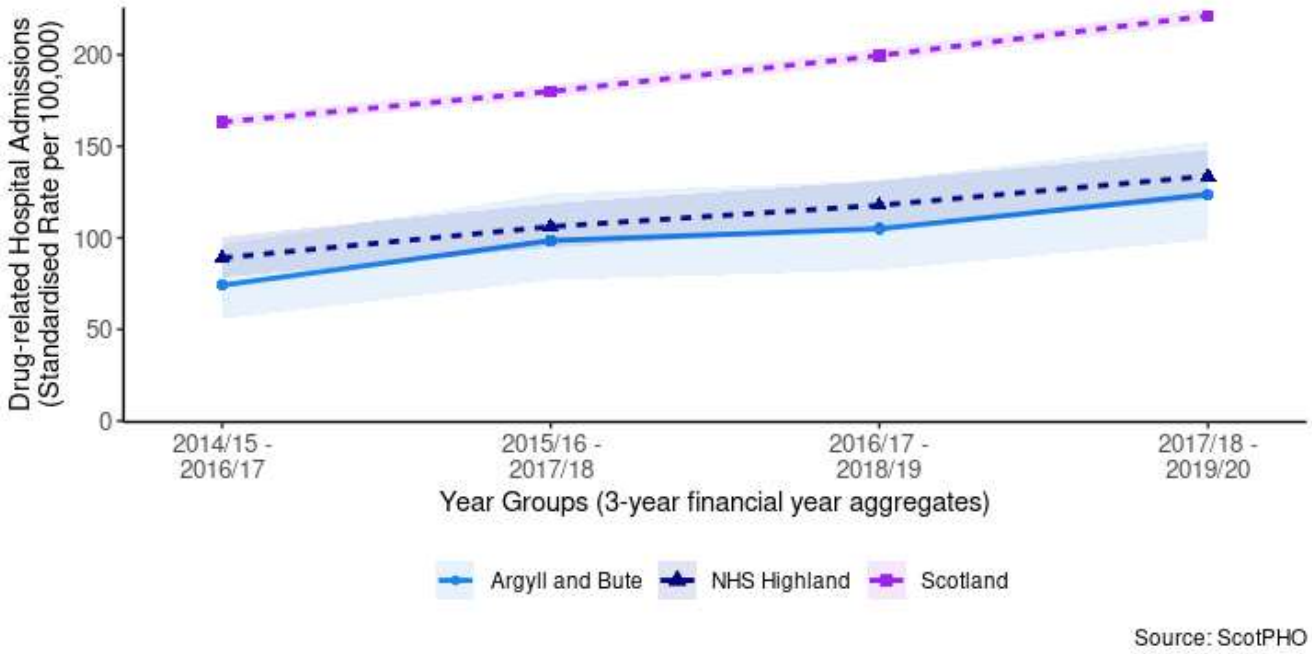
Drug-related Hospital Admissions

There were 124 drug-related hospital admissions per 100,000 age-sex standardised population[4] in Argyll and Bute HSCP for the most recent time period available (3 year financial year aggregate for 2017/18 - 2019/20).

This is a 68% increase since 2014/15 - 2016/17 (3 financial year aggregates).

A trend of the change in drug-related hospital admissions for Argyll and Bute HSCP compared with Scotland and NHS Highland is shown in the chart below from 2014/15 - 2016/17 onwards.

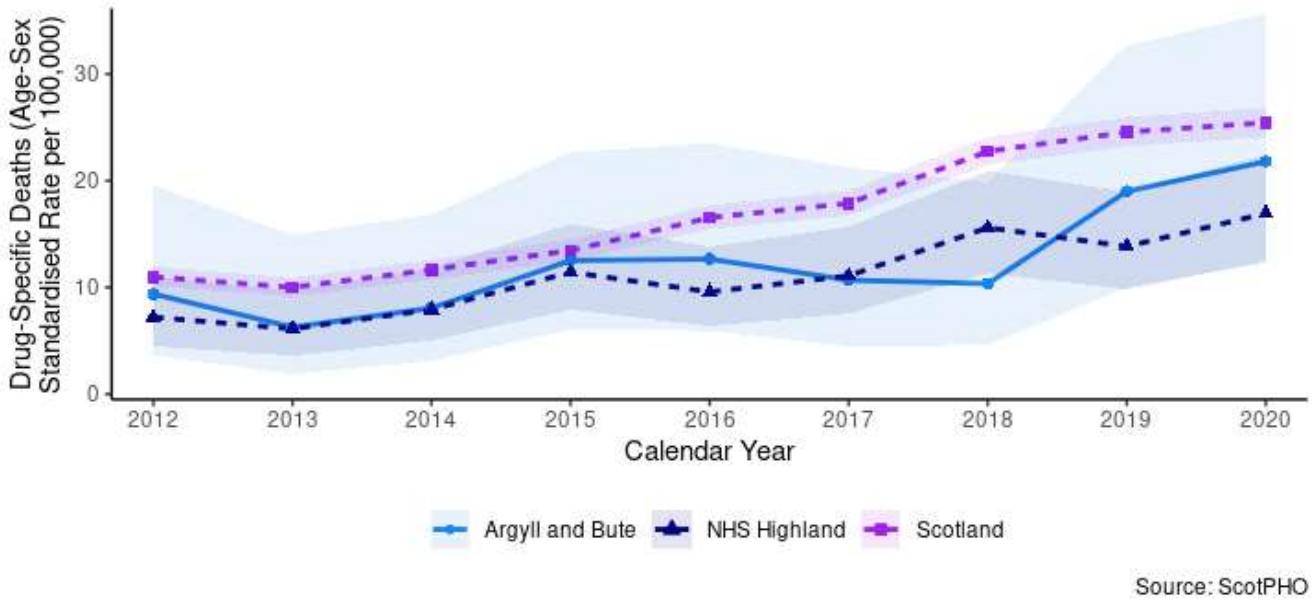
Figure 15: Trend of Drug-related Hospital Admission Rates by geographical area.



Drug-Specific Deaths

Data on alcohol-specific deaths is available per calendar year. The rate of drug-specific deaths is currently higher in Argyll and Bute than the rate in 2015 (74% change).

Figure 16: Trend of Drug-Specific Death Rates by geographical area.

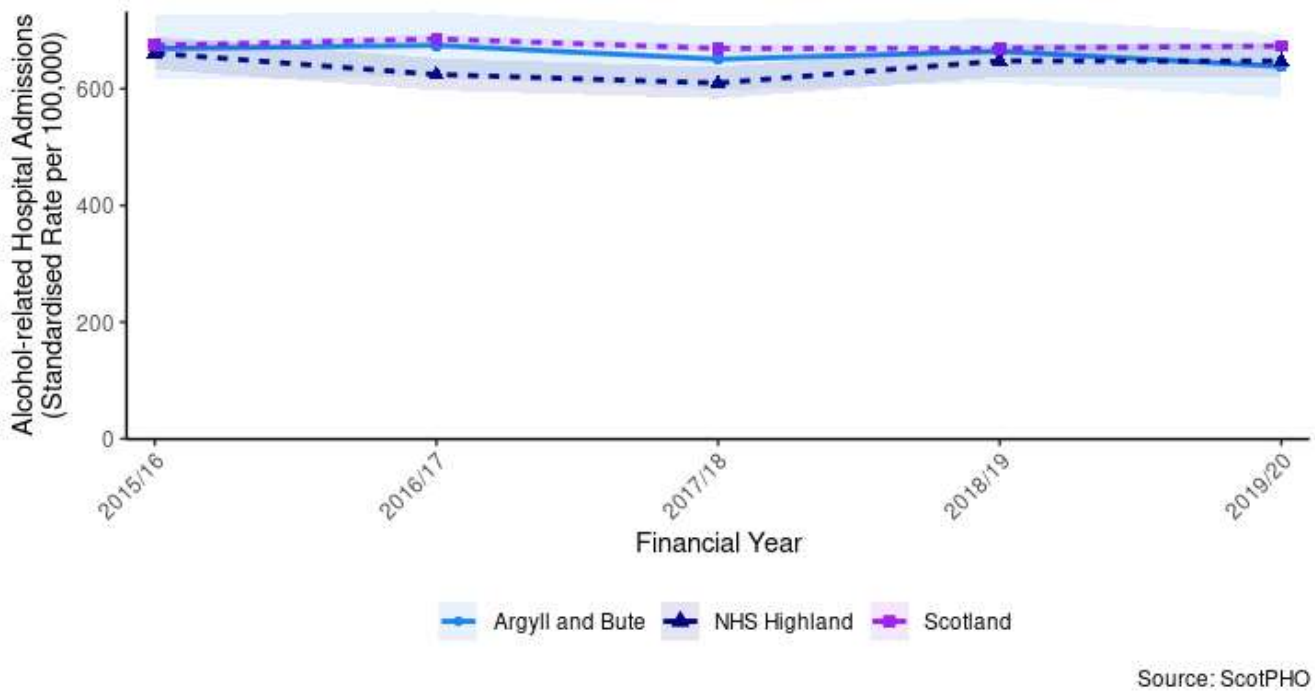


Alcohol-related Hospital Admissions

The 2019/20 alcohol-related admissions rate is 638 per 100,000 age-sex standardised population[4], which is a 4.6% decrease overall since 2015/16.

The chart below shows a trend of alcohol-related hospital admissions for Argyll and Bute HSCP compared with Scotland and NHS Highland from financial year 2015/16 to 2019/20.

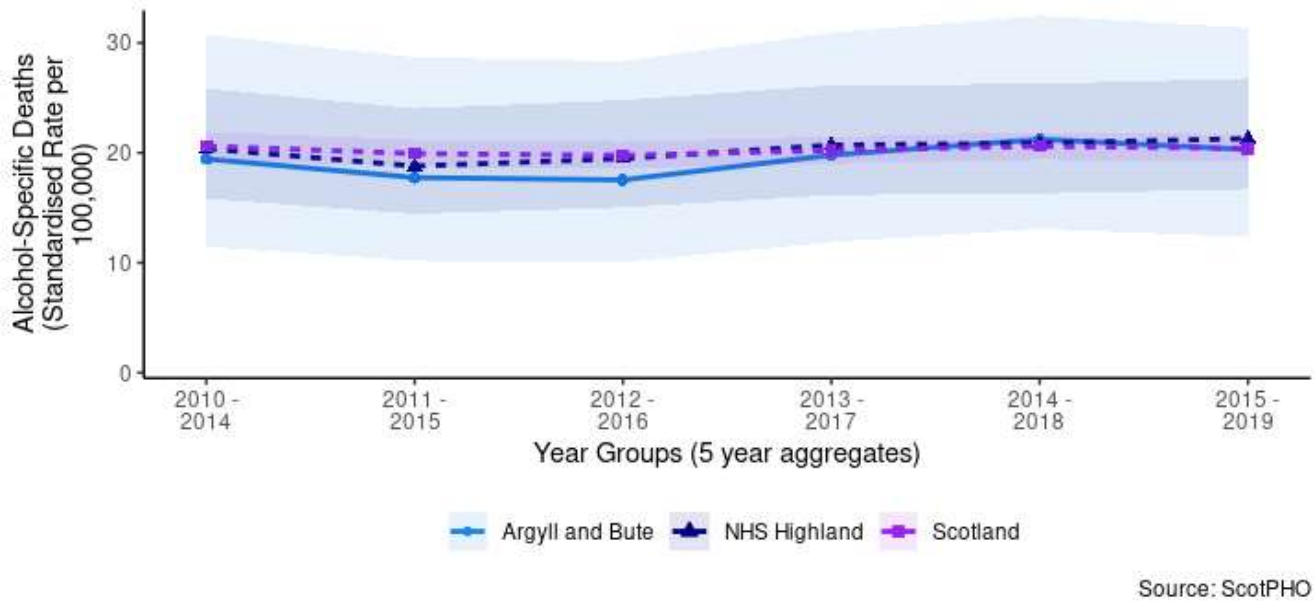
Figure 17: Trend of Alcohol-related Hospital Admission Rates by geographical area.



Alcohol-Specific Deaths

Data on alcohol-specific deaths is available as 5 year aggregates. The rate of alcohol-specific deaths is currently higher in Argyll and Bute than the rate in 2010 to 2014 (4.4% change).

Figure 18: Trend of Alcohol-Specific Death Rates by geographical area.

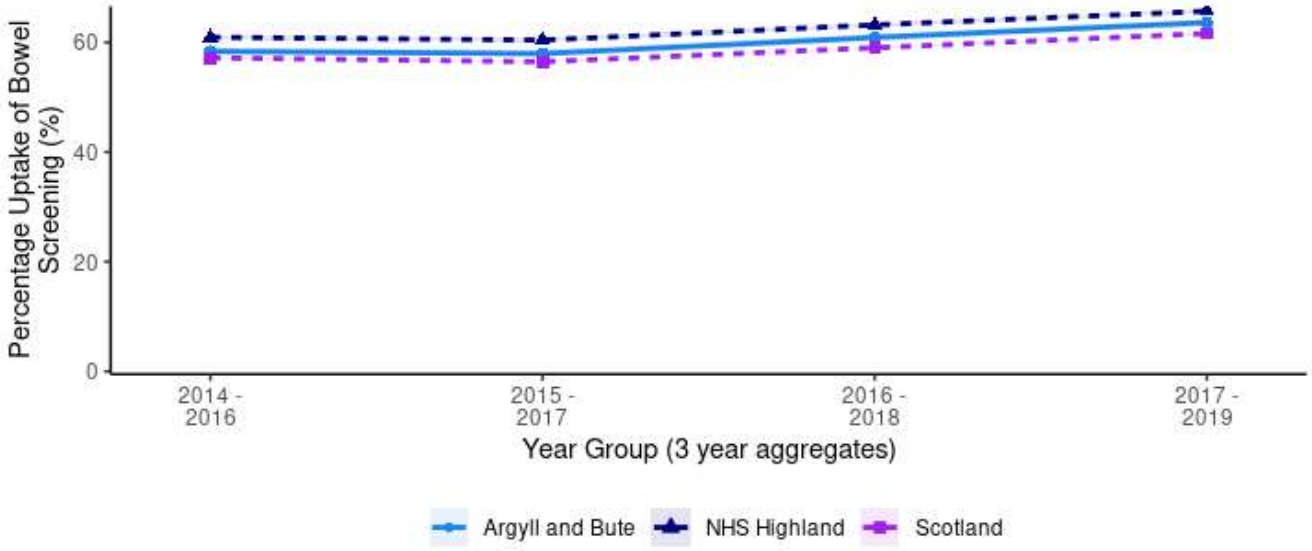


Bowel Screening Uptake

Bowel screening is offered every two years to eligible men and women aged between 50-74 years old. Eligible people are posted a test kit which is completed at home. Since 1st April 2013, those aged 75 and over can also self-refer and opt into screening. The uptake target for this program is 60%.

A trend of the percentage uptake of bowel screening among the eligible population is shown below for Argyll and Bute HSCP compared with Scotland and NHS Highland. Data is suppressed into 3 year aggregates. The 2017 - 2019 uptake rate for Argyll and Bute is **64%**.

Figure 19: Trend of Bowel Screening Uptake for eligible men and women, by geographical area.



Source: ScotPHO

Hospital and Community Care

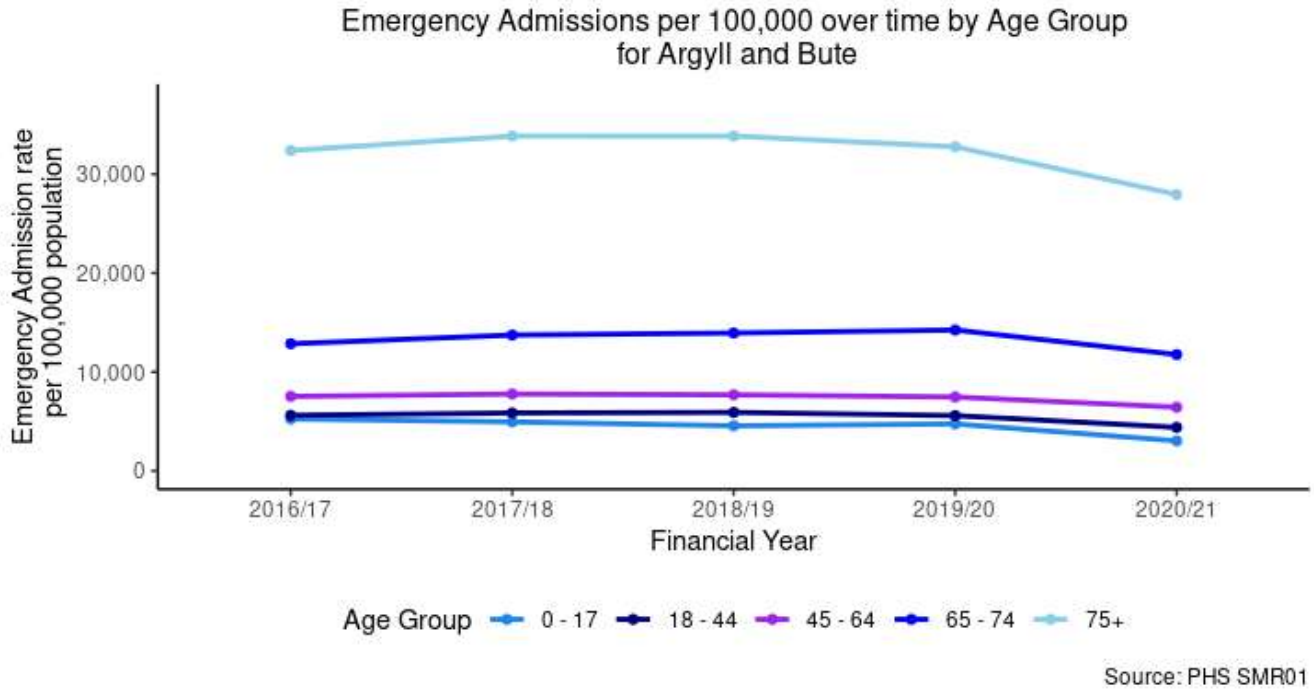
This section includes acute hospital data, delayed discharge bed days and A&E attendances. Please note that for 2020 onwards, hospital activity would have been severely affected by the COVID-19 pandemic. Information on how this has had a wider impact is provided in Footnote 4 at the end of the document.

For the most recent time periods available, Argyll and Bute had:

- **8,601** emergency hospital admissions per 100,000 population.
- **63,384** unscheduled acute specialty bed days per 100,000 population.
- **13,882** A&E attendances per 100,000 population.
- **7,527** delayed discharge bed days per 100,000 population.
- **819** emergency hospital admissions from falls per 100,000 population.
- **93** emergency readmissions (28 day) per 1,000 discharges.
- **1,041** potentially preventable hospital admissions per 100,000 population.
- People on average spent **92%** of their last 6 months of life in a community setting.

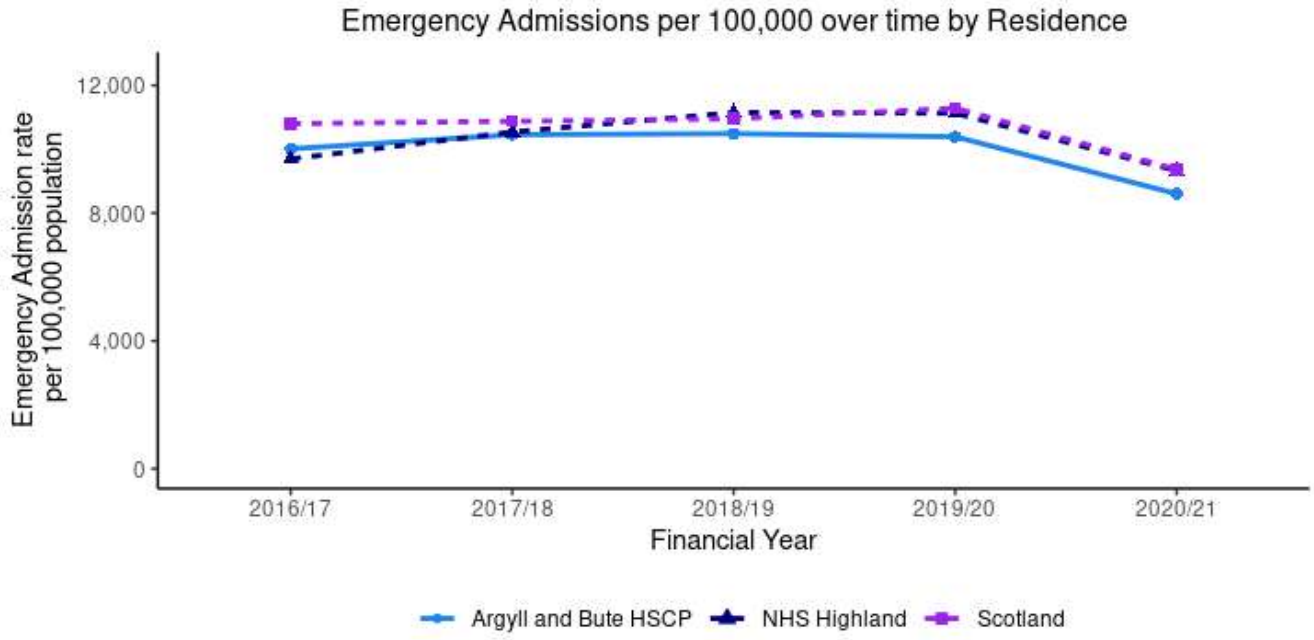
Emergency Admissions

Figure 20: Emergency admissions by age group



Source: PHS SMR01

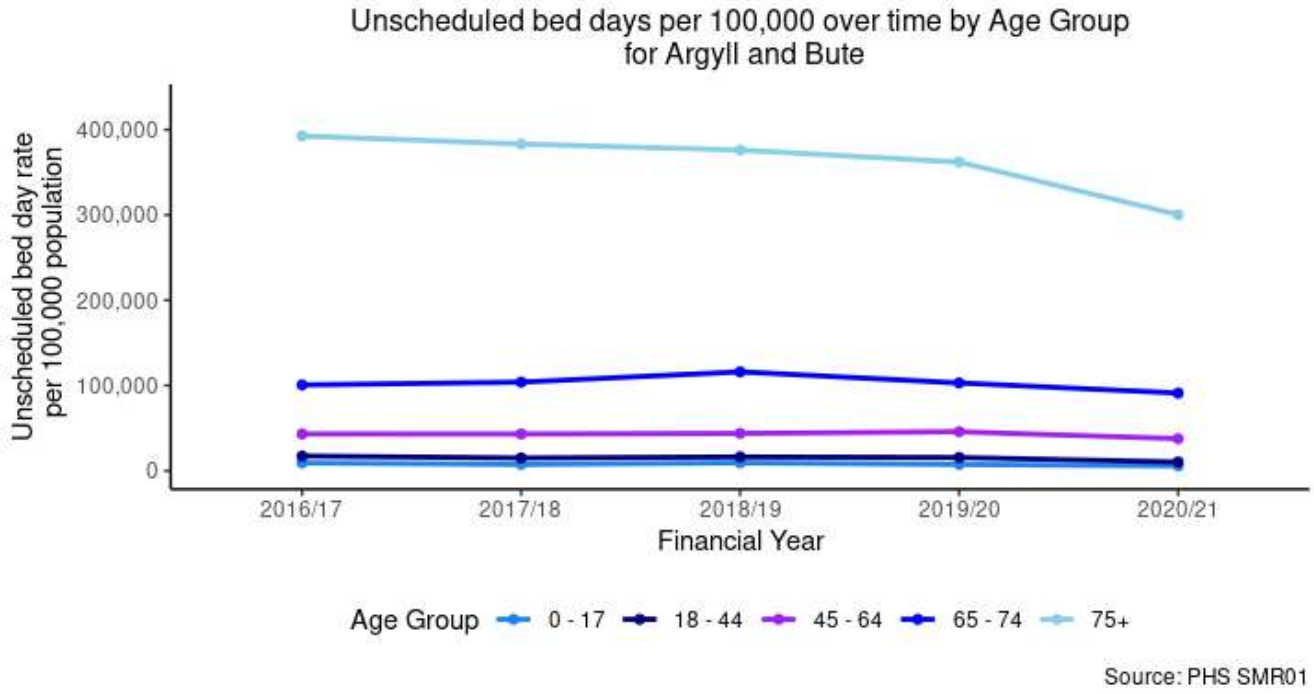
Figure 21: Emergency admissions by geographical area



Source: PHS SMR01

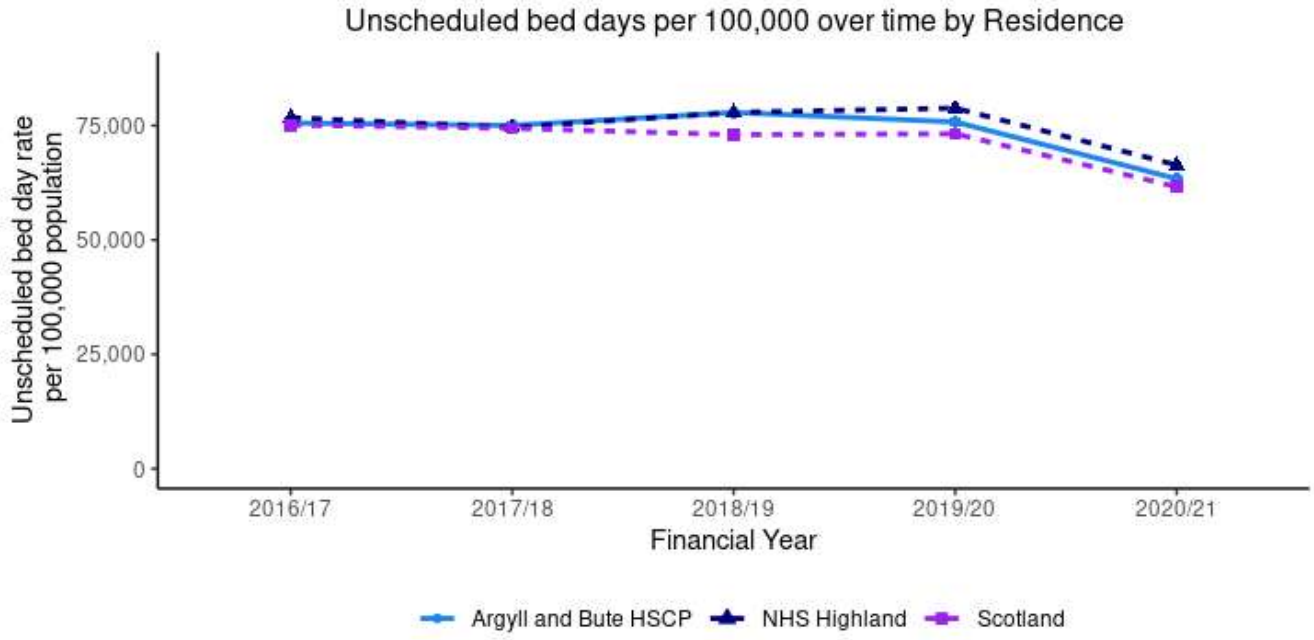
Unscheduled Acute Bed Days

Figure 22: Unscheduled bed days by age group



Source: PHS SMR01

Figure 23: Unscheduled bed days by geographical area



Source: PHS SMR01

A&E Attendances

Figure 24: A&E attendances by age group

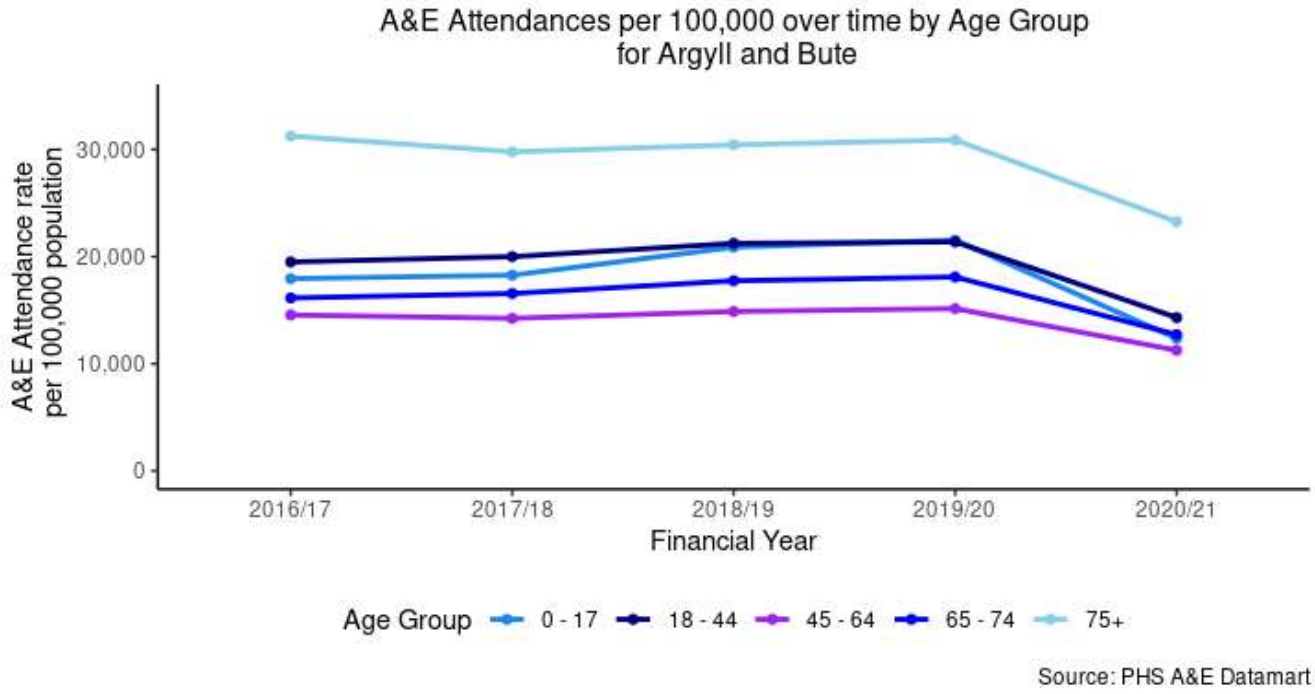
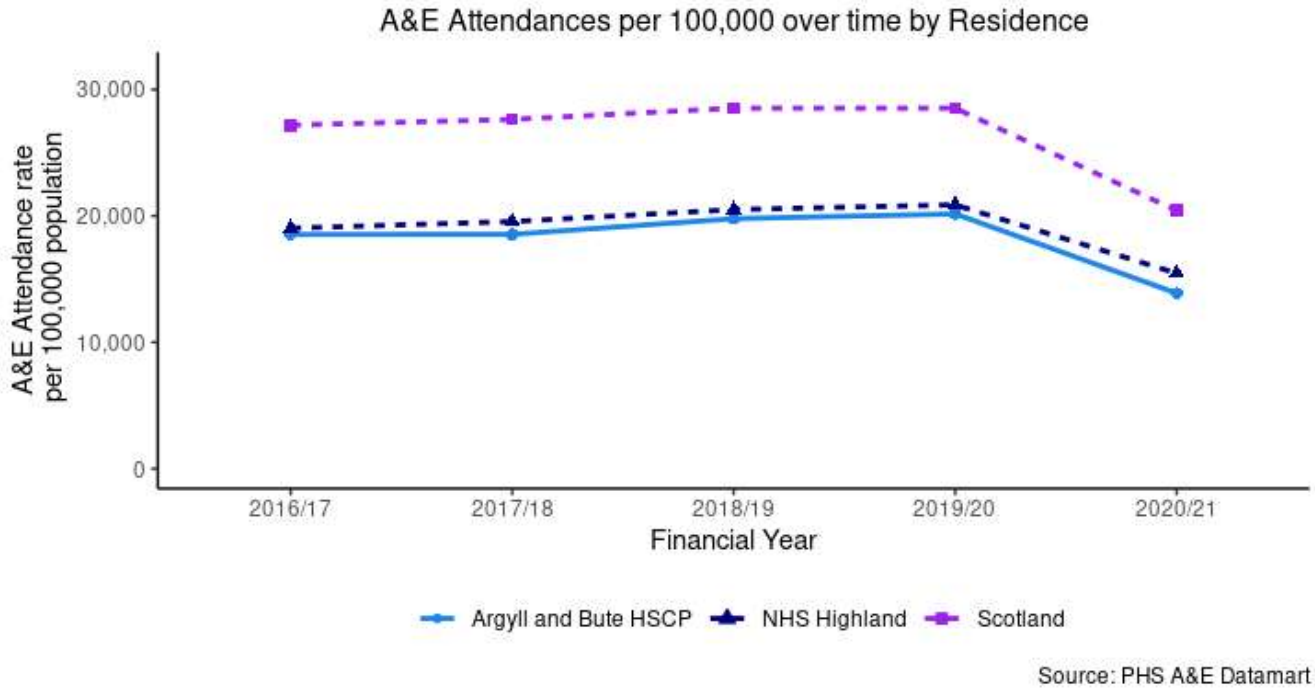
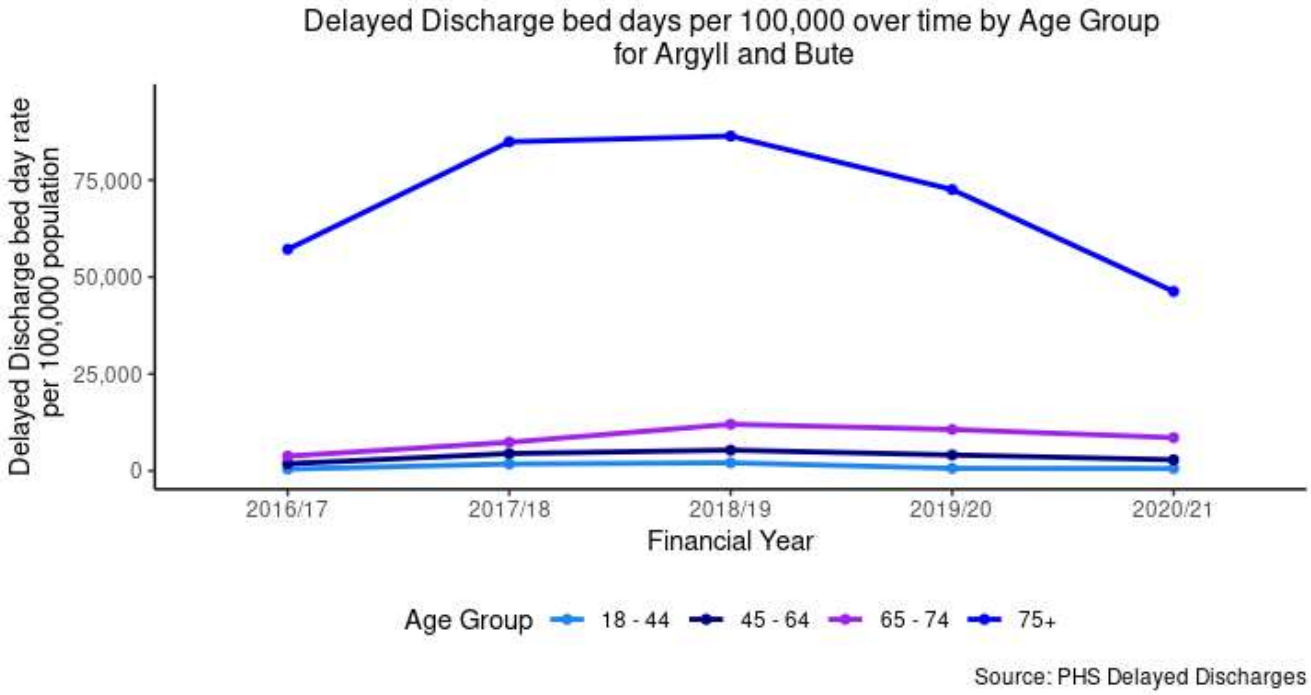


Figure 25: A&E attendances by geographical area



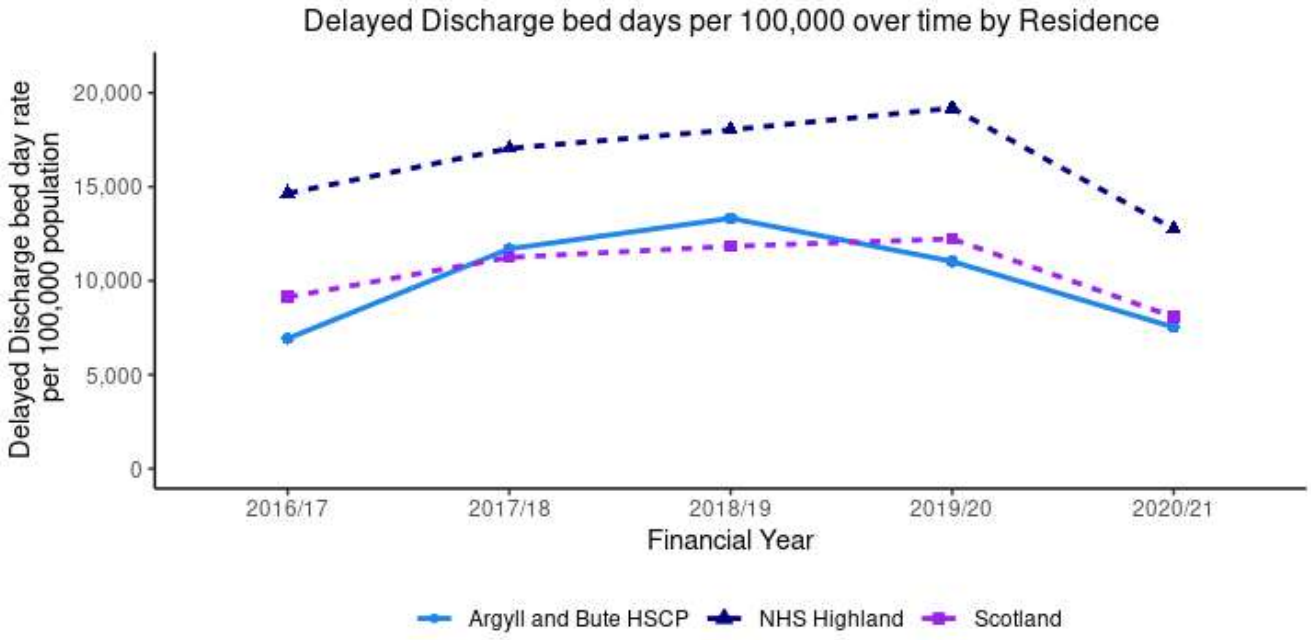
Delayed Discharge Bed Days

Figure 26: Delayed discharge bed days by age group



Source: PHS Delayed Discharges

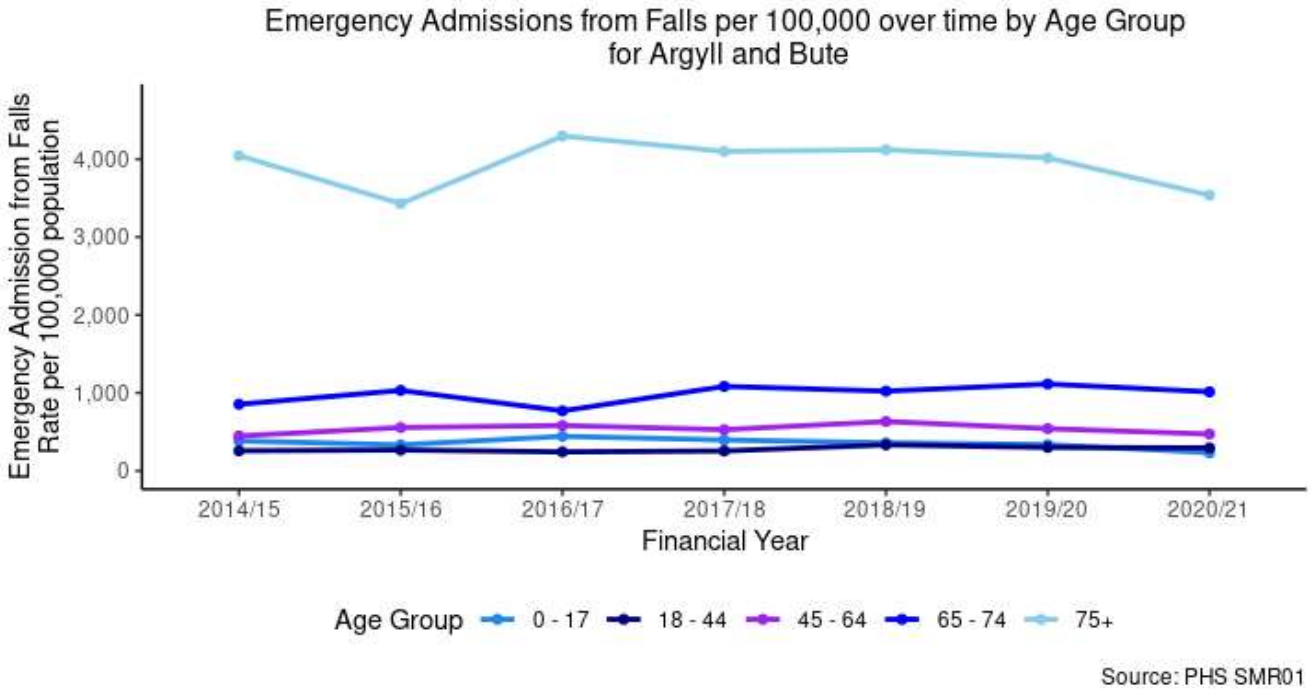
Figure 27: Delayed discharge bed days by geographical area



Source: PHS Delayed Discharges

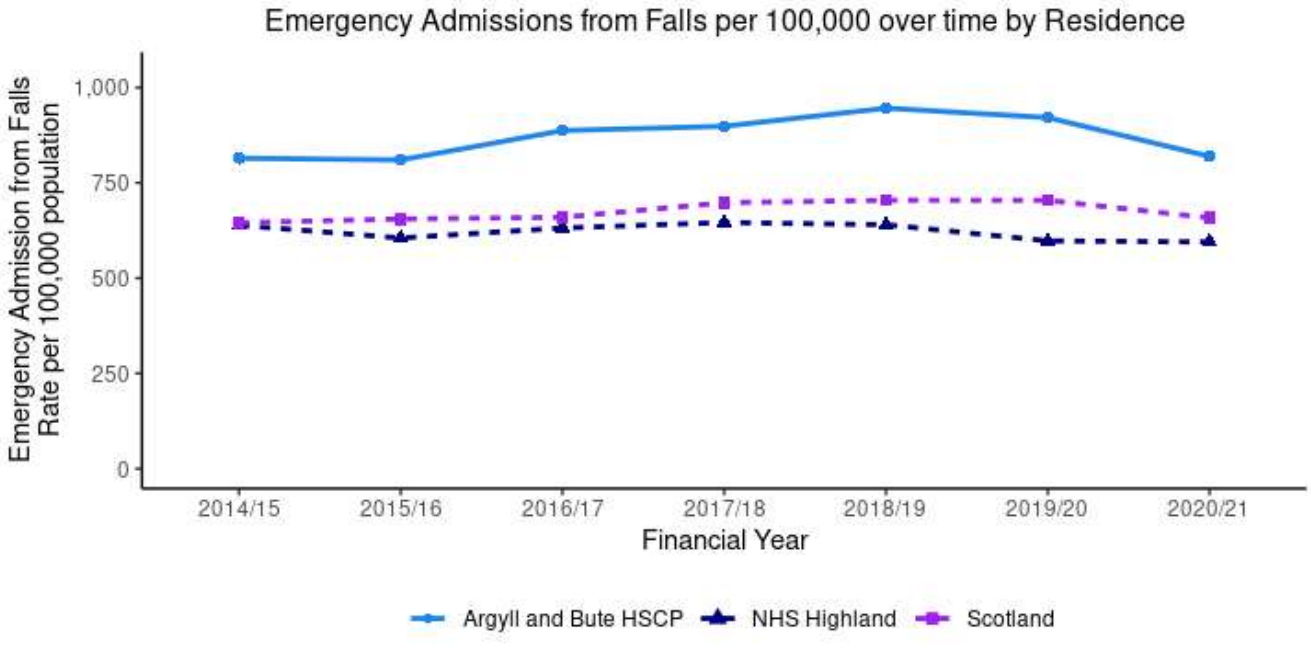
Emergency Admissions from a Fall

Figure 28: Falls by age group



Source: PHS SMR01

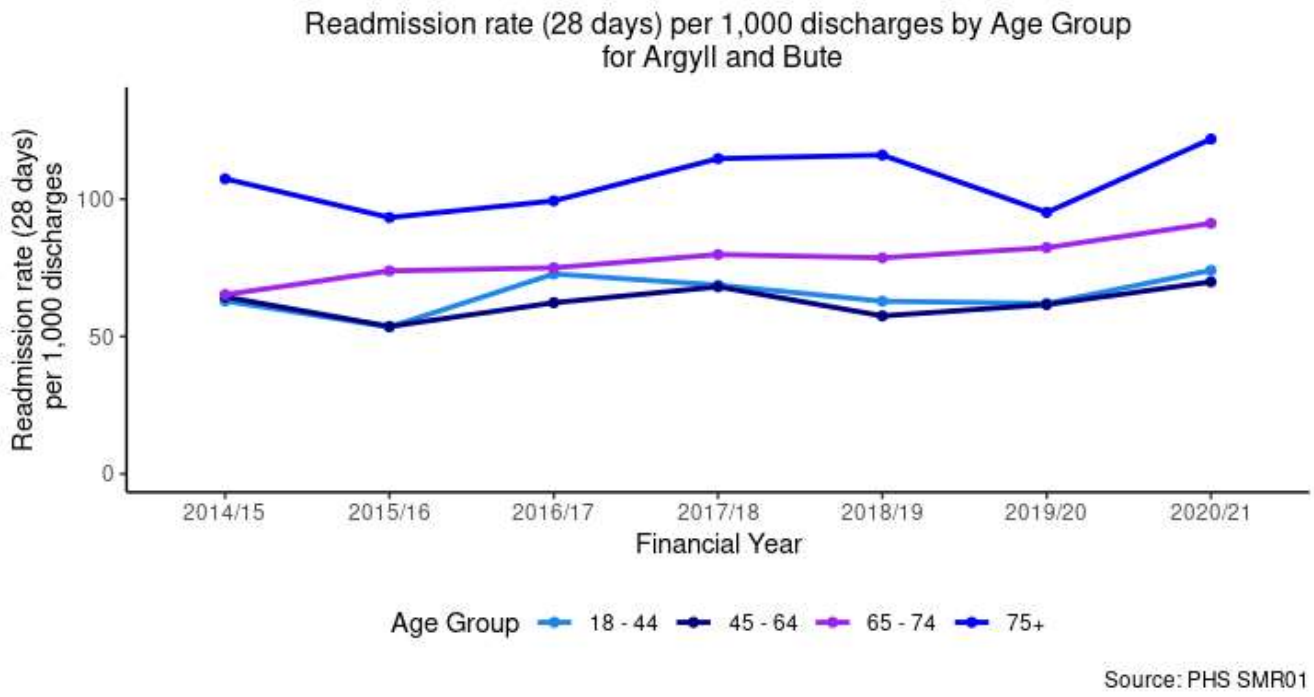
Figure 29: Falls by geographical area



Source: PHS SMR01

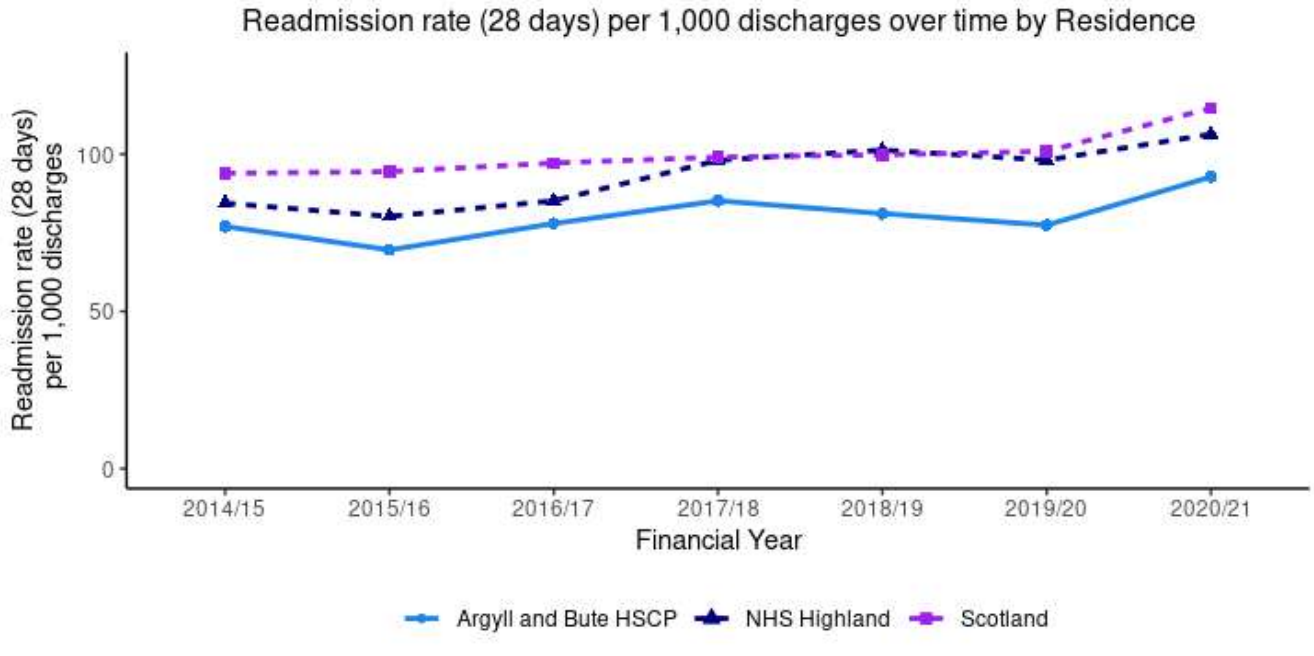
Emergency Readmissions (28 days)

Figure 30: Emergency readmissions by age group



Source: PHS SMR01

Figure 31: Emergency readmissions by geographical area

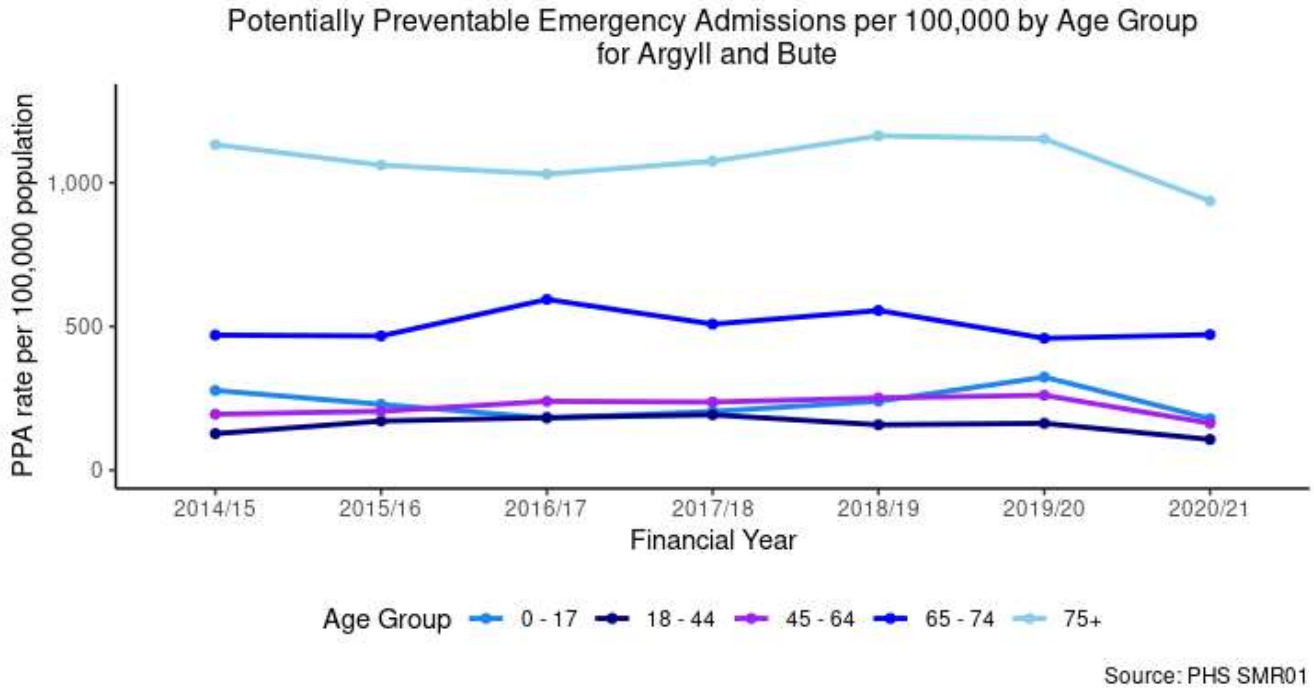


Source: PHS SMR01

Potentially Preventable Admissions (PPAs)

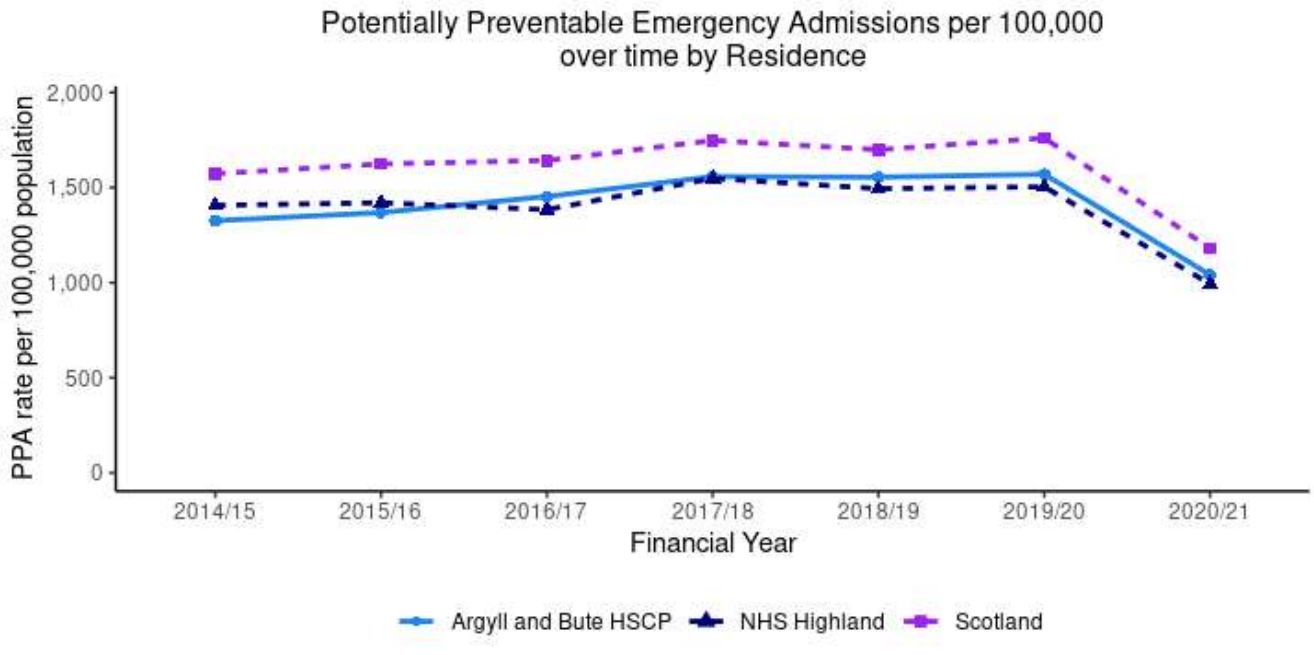
Information on which conditions are counted as PPAs is available in Appendix 3 of the summary document.

Figure 32: PPAs by age group



Source: PHS SMR01

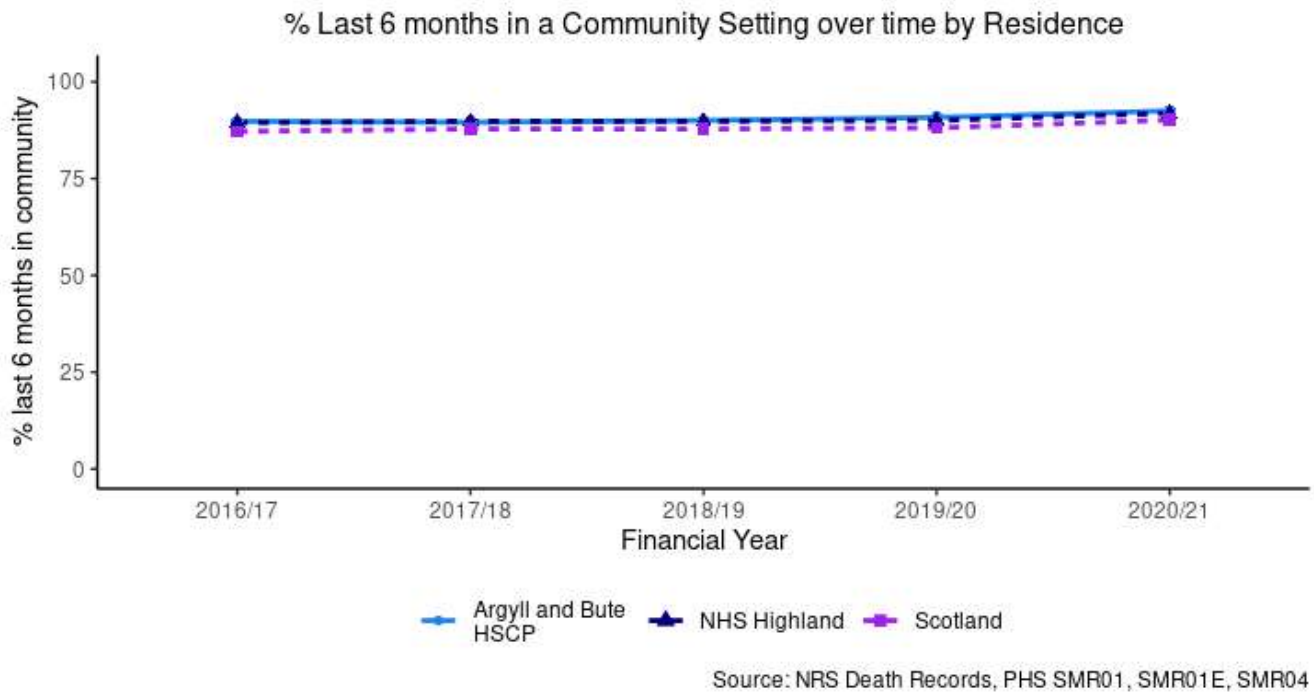
Figure 33: PPAs by geographical area



Source: PHS SMR01

Percentage Last 6 months in a Community Setting

Figure 34: Last 6 months in a community setting by geographical area



Footnotes

1. The data used in General Health and Behavioural Factors sections (except for long-term conditions) of this HSCP profile are taken from ScotPHO. There may be more recent data available for the indicators elsewhere.
2. Data taken from ScotPHO is often reported using the European Age-Sex Standardised Rate per 100,000. This allows for comparisons across different areas to be made. For more information on how these rates are calculated, please refer to www.isdscotland.org/Products-and-Services/GPD-Support/Population/Standard-Populations/
3. Physical long-term conditions data comes from the Source Linkage Files, and the conditions are identified using ICD-9 and ICD-10 codes in the diagnosis fields. Please note that the Source Linkage Files data only contains information on people who have had contact with the NHS through either inpatient admissions, outpatient attendances, day case attendances, A&E attendances or through prescribed items, the data does not show all service users in Scotland who have been diagnosed with an LTC as not all of these individuals will have used these services. Also note that LTC rates are based on an adjusted population indicator in the Source Linkage Files so that population sizes are closer to the official estimates.
4. The 2020 COVID-19 pandemic will have had an effect on the most recent data available. A dashboard has been created by PHS which show the wider impacts of COVID-19 over many areas. You can access this here: https://scotland.shinyapps.io/phs-covid-wider-impact/

This page is intentionally left blank

Public Health Scotland

LIST Profile 2020/21

HSCP and Localities

Summary

December 2021

Table of Contents

Notes for this profile:

- The island of Colonsay is located in the HSCP locality of 'Oban, Lorn and the Isles' (OLI) and within the local area of 'Mull, Iona, Coll, Tiree and Colonsay'. This reflects the organisation and delivery of HSCP services to Colonsay from OLI. However, to compile these profiles, data are aggregated from small geographical areas called datazones, for which different data are made available across Scotland. Colonsay is included within a datazone with Jura. This reflects the political multi-councillor ward in which Colonsay is placed with Islay, Jura and Kintyre (and falls within the Argyll and Bute Council Administrative Area of 'Mid-Argyll, Kintyre and Islay'). Colonsay is therefore included with Islay and Jura in the profile area of 'Islay, Jura and Colonsay'.
- All years shown are calendar years unless otherwise specified.
- Data sources are provided in the notes and the full profiles.
- Definitions for the indicators shown are available within the Appendices.
- The data here is a snapshot at one point in time. Data should be interpreted with caution, particularly for areas with relatively small population sizes where indicator data is expected, by chance alone, to have higher variation than in areas of larger population size. Please see full profiles for trends and confidence data. Note that differences between areas can relate to multiple factors including, for example, underlying rates of illness, rates of diagnosis and local differences in practice e.g. in data recording.

Figure 1: Map of GP practices by profile area in Argyll and Bute HSCP[1].

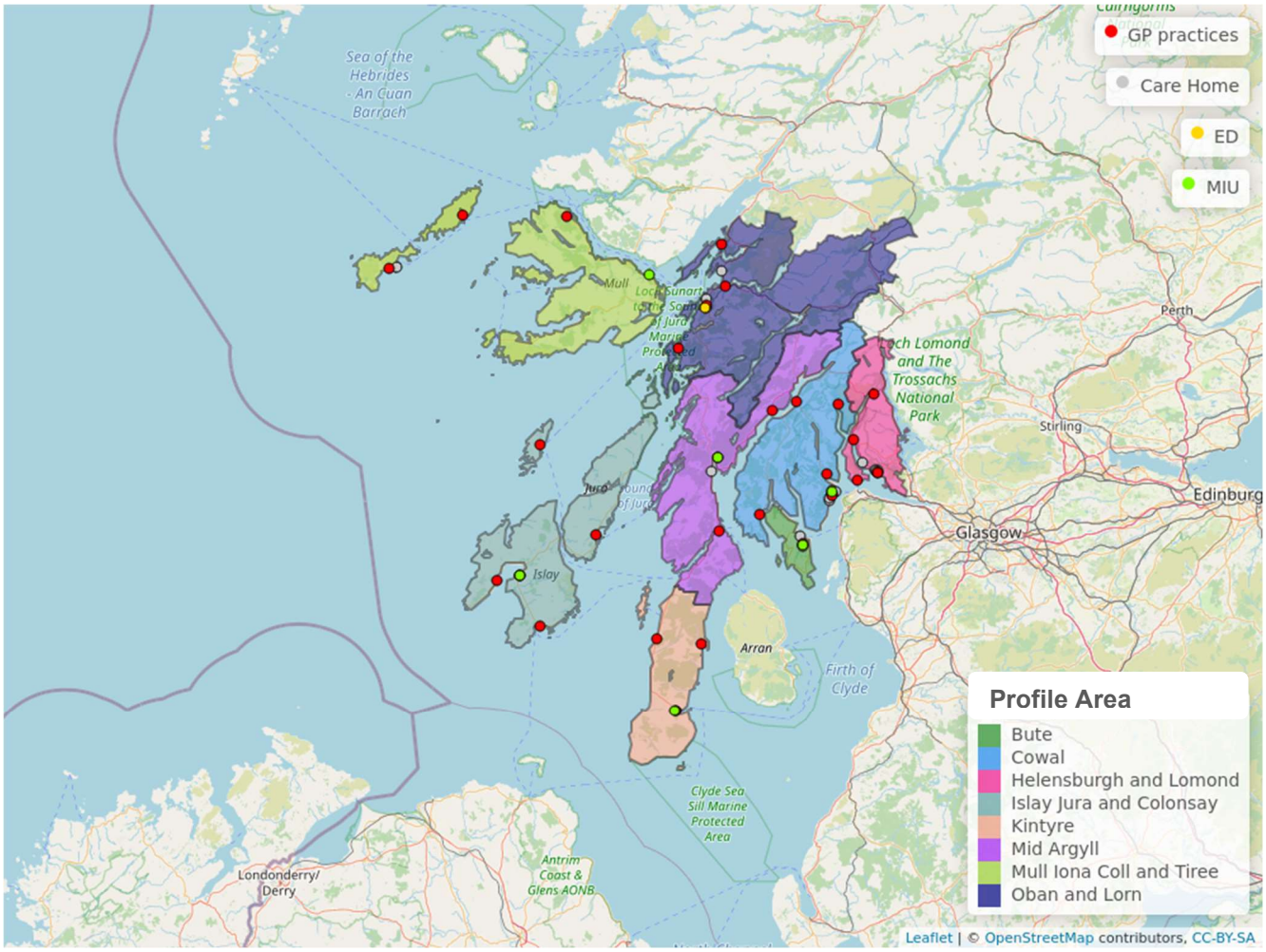


Table 1: Number of each type of services by area[1].

Service Type	Service	Bute	Cowal	H&L	Islay, Jura & Colonsay	Kintyre	Mid Argyll	Mull, Iona, Coll & Tiree	Oban and Lorn	Argyll and Bute HSCP
Primary Care	GP Practice	1	7	5	5	3	3	3	4	31
A&E	Emergency Department	0	0	0	0	0	0	0	1	1
	Minor Injuries Unit	1	1	0	1	1	1	1	0	6
Care Home	Elderly Care	2	4	4	1	1	1	1	3	17
	Other	0	1	4	0	0	0	0	3	8

Table 2: Summary data – snapshot[2]

Indicator	Data Type	Time Period	Bute	Cowal	H&L	Islay, Jura +	Kintyre	Mid Argyll	Mull, Iona, Coll +	Oban and Lorn	Argyll and Bute HSCP	Scotland
Demographics												
Total population	count	2020	5,986	14,014	25,715	3,380	7,375	9,118	3,747	16,095	85,430	5,466,000
Population over 65	%	2020	32.0	31.0	23.0	28.0	28.0	26.0	28.0	22.0	26.0	19.0
Population in least deprived SIMD quintile	%	2020	12.0	0.0	33.0	0.0	0.0	0.0	0.0	0.0	11.0	20.0
Population in most deprived SIMD quintile	%	2020	36.0	13.0	7.3	0.0	15.0	0.0	0.0	2.8	8.7	20.0
Housing												
Total number of households	count	2020	4,250	8,703	12,100	2,175	4,407	5,417	2,519	8,605	48,176	2,653,521
Households with single occupant tax discount	%	2020	36	34	32	29	35	32	28	33	33	38
Households in Council Tax Band A-C	%	2020	81	63	41	68	69	55	50	50	56	59
Households in Council Tax Band F-H	%	2020	4	8	29	6	6	14	17	18	16	13

Table 2: Summary data – snapshot[3,4,5] **At HSCP and Scotland level, the time period is a 3-year aggregate (2018-2020).*

Indicator	Data Type	Time Period	Bute	Cowal	H&L	Islay, Jura +	Kintyre	Mid Argyll	Mull, Iona, Coll +	Oban and Lorn	Argyll and Bute HSCP	Scotland
General Health												
Male average life expectancy in years	mean	2016-2020*	75.4	77.1	80	77.4	77.1	78.4	76.9	77.4	78	76.8
Female average life expectancy in years	mean	2016-2020*	81.7	80.1	82.5	82.3	81.5	82.6	85.5	82.2	81.6	81
Early mortality rate per 100,000	rate	2018-2020	225	152	77	30	151	110	66	95	106	116
Population with long-term condition	%	2020/21	26	27	21	25	26	24	23	24	25	20
Cancer registrations per 100,000	rate	2017-2019	604	610	627	472	642	539	697	629	609	644
Anxiety, depression & psychosis prescriptions	%	2019/20	22	23	16	24	21	18	19	18	19	20
Behavioural Factors												
Drug-related hospital admissions per 100,000	rate	2017/18 - 2019/20	122	188	130	18	48	65	18	187	124	221
Alcohol-related hospital admissions per 100,000	rate	2019/20	623	871	536	726	590	620	333	800	638	673
Alcohol-specific mortality per 100,000	rate	2015 - 2019	22	14	18	28	34	24	21	19	20	20
Bowel screening uptake	%	2017 - 2019	59	62	65	69	63	63	66	63	64	62

Table 2: Summary data - snapshot[6]

Indicator	Data Type	Time Period	Bute	Cowal	H&L	Islay, Jura +	Kintyre	Mid Argyll	Mull, Iona, Coll +	Oban and Lorn	Argyll and Bute HSCP	Scotland
Hospital and Community Care												
Emergency admissions per 100,000	rate	2020/21	8,002	9,890	7,482	7,959	8,990	8,763	7,259	9,668	8,601	9,368
Unscheduled acute bed days per 100,000	rate	2020/21	66,338	81,183	52,487	65,592	72,081	54,859	54,337	66,685	63,384	61,622
A&E attendances per 100,000	rate	2020/21	3,508	4,645	19,541	2,751	2,237	4,891	7,686	30,947	13,882	20,422
Delayed discharge bed days per 100,000	rate	2020/21	4,162	9,291	5,159	6,728	6,632	9,837	7,767	9,921	7,527	8,080
Falls emergency admissions per 100,000	rate	2020/21	936	921	568	1,154	651	998	934	969	819	658
Emergency readmissions per 1,000	rate	2020/21	70	88	82	66	103	92	75	136	93	115
Last 6 months of life spent in community	%	2020/21	94	93	93	93	90	92	94	92	92	90
Potentially Preventable Admissions per 100,000	rate	2020/21	952	1,249	863	740	976	823	827	1,441	1,041	1,181

Footnotes

1. Care Home Data included in the Services Map and Table was sourced from the Care Inspectorate. GP Practice data from October 2021, and Hospital and A&E data was sourced from Public Health Scotland Open Data. Only services that are within the physical boundary of the HSCP or Locality are included in the map and table, so there may be services outside Argyll and Bute which people may use but are not shown.
2. The data used in Demographics and Housing sections (except SIMD) are taken from National Records of Scotland (NRS). SIMD data from PHS incorporates SIMD information from Scottish Government and population data from NRS.
3. The data used in General Health and Behavioural Factors sections (except for long-term conditions) of this locality profile are taken from ScotPHO. There may be more recent data available for the indicators elsewhere.
4. Data taken from ScotPHO is often reported using the European Age-Sex Standardised Rate per 100,000. This allows for comparisons across different areas to be made. For more information on how these rates are calculated, please refer to www.isdscotland.org/Products-and-Services/GPD-Support/Population/Standard-Populations/
5. Physical long-term conditions (LTC) data comes from the Source Linkage Files, and the conditions are identified using ICD-9 and ICD-10 codes in the diagnosis fields. Please note that the Source Linkage Files data only contains information on people who have had contact with the NHS through either inpatient admissions, outpatient attendances, daycase attendances, A&E attendances or through prescribed items, the data does not show all service users in Scotland who have been diagnosed with an LTC as not all of these individuals will have used these services. Also note that LTC rates are based on an adjusted population indicator in the Source Linkage Files so that population sizes are closer to the official estimates.
6. Hospital and Community care data are sourced from PHS data sources and NRS death records.

Appendices

Appendix 1: Indicator Definitions

Indicator	Definition
% last 6 months of Life Spent in a Community Setting	The percentage of time spent by people in their last 6 months of life in the community. Community includes care home residents as well as those living in their own home. Considers all hospital activity (e.g. geriatric long stay (GLS), mental health, acute). Inpatient activity with a care home location code recorded in SMR is included within the Community percentage for all years presented. This activity represents beds funded by the NHS which are located within a care home.
A&E Attendances	Attendance rates to A&E departments for patients by residence per 100,000 population. Includes all ages.
Alcohol-related hospital admissions	General acute inpatient and day case stays with diagnosis of alcohol misuse in any diagnostic position (ICD-10 code: E24.4, E51.2, F10, G31.2, G62.1, G72.1, I42.6, K29.2, K70, K85.2, K86.0, O35.4, P04.3, Q86.0, R78.0, T51.0, T51.1, T51.9, X45, X65, Y15, Y57.3, Y90, Y91, Z50.2, Z71.4, Z72.1). All rates have been standardised against the European standard population (ESP2013) and 2011-based population estimates.
Alcohol-specific deaths	Alcohol related deaths (based on new National Statistics definition): 5-year rolling average number and directly age-sex standardised rate per 100,000 population. (ICD-10 codes from the primary cause of death: E24.4,F10,G31.2,G62.1,G72.1,I42.6,K29.2,K70,K85.2,K86.0,Q86.0, R78.0,X45,X65,Y15).
Bowel Screening Uptake	Bowel screening uptake for all eligible men and women invited (aged 50-74): 3-year rolling average number percentage. Eligible men and women are posted a guaiac-based faecal occult blood test kit (FOBT) which should be completed at home. This involves collecting 2 samples from each of 3 separate bowel movements. The kit is returned in a pre-paid envelope to the central screening centre in Dundee and tested for hidden traces of blood in the stool. Individuals who have a positive FOBT result are referred to their local hospital for assessment and, where appropriate, offered a colonoscopy as the first line of investigation.
Cancer Registrations	New cancer registrations: 3 year rolling average number and directly age-sex standardised rate per 100,000 population. All rates have been standardised against the European standard population (ESP2013) and 2011-base population estimates. ICD10: C00-C96 excluding C44 (principal diagnosis only).
Death, aged 15-44	Deaths from all causes (ages 15-44 years), 3 year rolling average number and directly age sex standardised rate per 100,000 population. All rates have been standardised against the European

	standard population (ESP2013). Deaths assigned to year based on death registration date.
Delayed Discharge Bed days	Number of days people aged over 18 spend in hospital when they are ready to be discharged per 100,000 population. Note that this may not always reflect the council area responsible for the person's post hospital discharge planning. The HSCP total is based on the area responsible for the person's post hospital discharge planning, which reflects what is published nationally.
Drug-related hospital admissions	General acute inpatient and day case stays with diagnosis of drug misuse in any diagnostic position (ICD10: F11-F16, F18, F19, T40.0-T40.9), 3-year rolling average number and directly age-sex standardised rate per 100,000 population. All rates have been standardised against the European standard population (ESP2013) and 2011-based population estimates.
Emergency Admissions	Rate of emergency (non-elective) admissions of patients of all ages per 100,000 population. This has been separated into two indicators – one for acute specialty and one for mental health specialty stays. An emergency admission is defined as being a new continuous spell of care in hospital where the patient was admitted as an emergency. The total number of emergency admissions is then calculated by counting the number of continuous spells in hospital within a financial year. (See also the "Hospital Care in Mental Health Specialities" definition).
Emergency Admissions from a Fall	Rate of acute emergency admissions (non-elective) of patients of all ages where a fall was logged as an ICD-10 code. ICD-10 codes W00-W19 were searched for in all diagnostic positions, in conjunction with the admission type codes 33 (Patient injury, home accident), 34 (Patient injury, incident at work) and 35 (Patient injury, other).
Emergency Readmissions (28 day)	The rate of readmissions of all adults (18+) within 28 days of an admission per 1,000 discharges. An emergency readmission is where the subsequent admission is an emergency and occurs up to and including 28 days from the initial admission. The initial admission can be of any type but must end within the time period of interest
Hospital Care in Mental Health Specialties	Mental health admission data is taken from SMR04, which holds records on patients receiving inpatient care in mental health (psychiatric) facilities. Episodes beginning with a transfer have also been included in these figures, as well as emergency admissions as many of these episodes will have started as unplanned acute admission. Therefore the initial unscheduled admission need not have been to a mental health long stay speciality.
Life expectancy, females	Estimated female life expectancy at birth in years, multi-year average (over 3 years for NHS Boards and Local Authorities, 5 years for Intermediate zones). Mortality data are based on year of registration. They also include non-Scottish residence so the number of deaths match those produced by NRS.

Life Expectancy, males	Estimated male life expectancy at birth in years, multi-year average (over 3 years for NHS Boards and Local Authorities, 5 years for Intermediate zones) Mortality data are based on year of registration. They also include non-Scottish residence so the number of deaths match those produced by NRS.
Physical Long-Term Conditions	Health conditions that last a year or longer, impact a person's life, and may require ongoing care and support. The LTCs presented are: Arthritis, Atrial Fibrillation, Cancer, Coronary Heart Disease, Chronic Obstructive Pulmonary Disease (COPD), Cerebrovascular Disease, Dementia, Diabetes, Epilepsy, Heart Failure, Liver Failure, Multiple Sclerosis, Parkinson's, and Renal Failure.
Population prescribed drugs for anxiety/depression/psychosis	Estimated number and percentage of population being prescribed drugs for anxiety, depression or psychosis.
Potentially Preventable Admissions (PPA)	Emergency admissions (non-elective) of patients of all ages for conditions based on 19 “ambulatory care sensitive conditions” from “The health of the people of NEW South Wales - Report of the Chief Medical Officer". These conditions result from medical problems that may be avoidable with the application of public health measures and/or timely and effective treatment usually delivered in the community by the primary care team. Please see complete list of ICD-10 codes included in Appendix 3.
Unscheduled Bed days	Rate of unscheduled bed days of patients of all ages per 100,000 population. Takes the bed days spent only within the year of measurement – stays that overlap financial years will have their respective days counted either side. This has been separated into two indicators – one for acute speciality and one for mental health specialty stays.

Appendix 2: Date of Indicator Data Extractions

Section	Indicator	Date of data extraction
Demographics	Population structure	2021-09-09
Demographics	Population projection	2021-09-09
Demographics	SIMD2016	2021-09-09
Demographics	SIMD2020	2021-09-09
Households	Household estimates	2021-10-06
Households	Household in each council tax band	2021-10-06
Services	GP Practice locations	2021-10-08
Services	Care Home locations	2021-10-08
Services	A&E locations	2021-10-08
General Health	Life expectancy males	2021-10-08
General Health	Life expectancy females	2021-10-08
General Health	Deaths ages 15-44 years	2021-10-09
General Health	LTC multimorbidity	2021-10-09
General Health	New cancer registrations	2021-10-09
General Health	% and number of people with a prescription for anxiety, depression or psychosis	2021-10-09
Behavioural Factors	Drug-related hospital admissions	2021-10-18
Behavioural Factors	Alcohol-related hospital admissions	2021-10-18
Behavioural Factors	Alcohol-specific mortality	2021-10-18
Behavioural Factors	Bowel screening uptake	2021-10-18
Hospital and Community Care	Emergency Admissions (Acute)	2021-10-18
Hospital and Community Care	Unscheduled bed days (Acute)	2021-10-18
Hospital and Community Care	A&E Attendances	2021-10-18
Hospital and Community Care	Delayed discharge bed days	2021-10-18
Hospital and Community Care	Fall emergency admissions	2021-10-18
Hospital and Community Care	Emergency Readmissions (28 day)	2021-10-18

Hospital and Community Care	% last 6 months in community setting	2021-10-18
Hospital and Community Care	Potentially Preventable Admissions (PPAs)	2021-10-18

Appendix 3: Conditions included as Potentially Preventable Admissions (PPAs)

Condition	ICD10 codes included	Comments
Ear Nose And Throat	H66, J028, J029, J038, J039, J06, J321	NA
Dental	K02, K03, K04, K05, K06, K08	NA
Convulsions And Epilepsy	G40, G41, R56, O15	NA
Gangrene	R02	NA
Nutritional Deficiencies	E40, E41, E43, E550, E643, M833	NA
Dehydration And Gastroenteritis	E86, K522, K528, K529	NA
Pyelonephritis	N10, N11, N12	NA
Perforated Bleeding Ulcer	K250, K251, K252, K254, K255, K256, K260, K261, K262, K264, K265, K266, K270, K271, K272, K274, K275, K276, K280, K281, K282, K284, K285, K286	Excludes episodes with following main OPCS4 codes: S06, S57, S68, S70, W90, X11
Cellulitis	L03, L04, L080, L088, L089, L980	NA
Pelvic Inflammatory Disease	N70, N73	NA
Influenza And Pneumonia	J10, J11, J13, J181	NA
Other Vaccine Preventable	A35, A36, A370, A379, A80, B05, B06, B161, B169, B26	NA
Iron Deficiency	D501, D508, D509	NA
Asthma	J45, J46	NA
Diabetes Complications	E100, E101, E102, E103, E104, E105, E106, E107, E108, E110, E111, E112, E113, E114, E115, E116, E117, E118, E120, E121, E122, E123, E124, E125, E126, E127, E128, E130, E131, E132, E133, E134, E135, E136, E137, E138, E140, E141, E142, E143, E144, E145, E146, E147, E148	NA
Hypertension	I10, I119	Exclude episodes with following main OPCS4 codes: K01 - K50, K56, K60 - K61
Angina	I20	Exclude episodes with main OPCS4 codes:

		K40, K45 K49, K60, K65, K66
COPD	J20, J41, J42, J43, J44, J47	J20 only included if secondary diagnosis has one of J41 - J44, J47
Congestive Heart Failure	I110, I50, J81	Exclude episodes with following main OPCS4 codes: K01 - K50, K56, K60 - K61

This page is intentionally left blank

Locality Profile

Bute Locality

October 2021

Table of Contents

Notes for this profile:

- All years shown are calendar years unless otherwise specified.
- Upper and lower 95% confidence intervals are shown throughout this document where available. In charts, these are displayed as shaded areas either side of trend lines, or as black error bars in bar charts. Confidence intervals show the range of possible values and a certainty that the true value falls within them.
- Definitions for the indicators shown are available in Appendix 1 in the accompanying summary document.
- Any zero figures for some indicators will indicate either suppression of small data or a complete lack of data available for this locality
- Data should be interpreted with caution, particularly for areas with relatively small population sizes where indicator data is expected, by chance alone, to have higher variation than in areas of larger population size. Note that differences between areas can relate to multiple factors including, for example, underlying rates of illness, rates of diagnosis and local differences in practice e.g. in data recording.

Demographics

Summary:

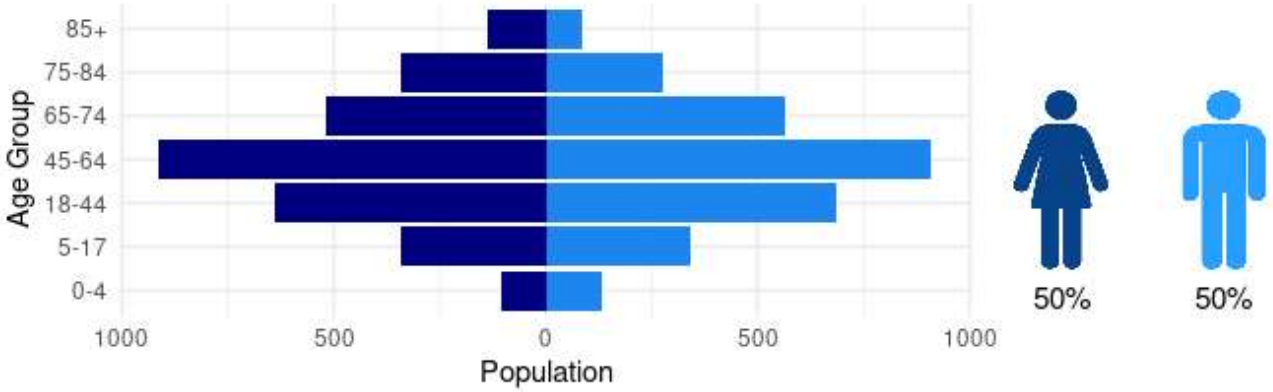
For the most recent time periods available, Bute Locality had:

- A total population of **5,986** people, where **50%** were male, and **32%** were aged over 65.
- **12%** of people lived in the least deprived SIMD quintile, and **36%** lived in the most deprived quintile.

Population

In 2020, the total population of Bute locality was 5,986. The graph below shows the population distribution of the locality.

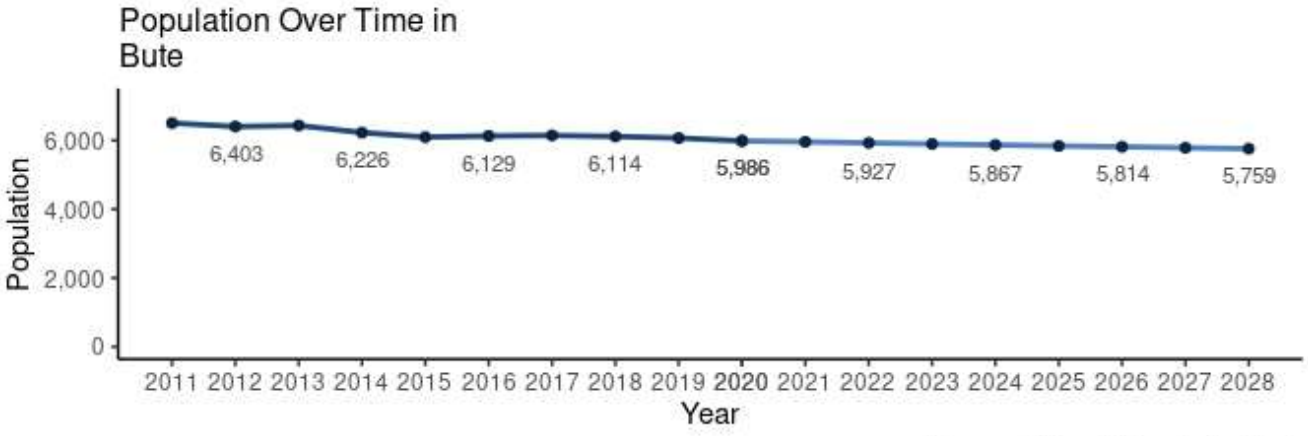
Figure 1: Population breakdown in Bute.



Source: National Records Scotland

Figure 2 shows the historical population of Bute, along with the NRS population projections. The population has been falling. The population in Bute is estimated to decrease by 2.5% from 2020 to 2025 *Please see the footnotes for more information on how the population projections were calculated*[1].

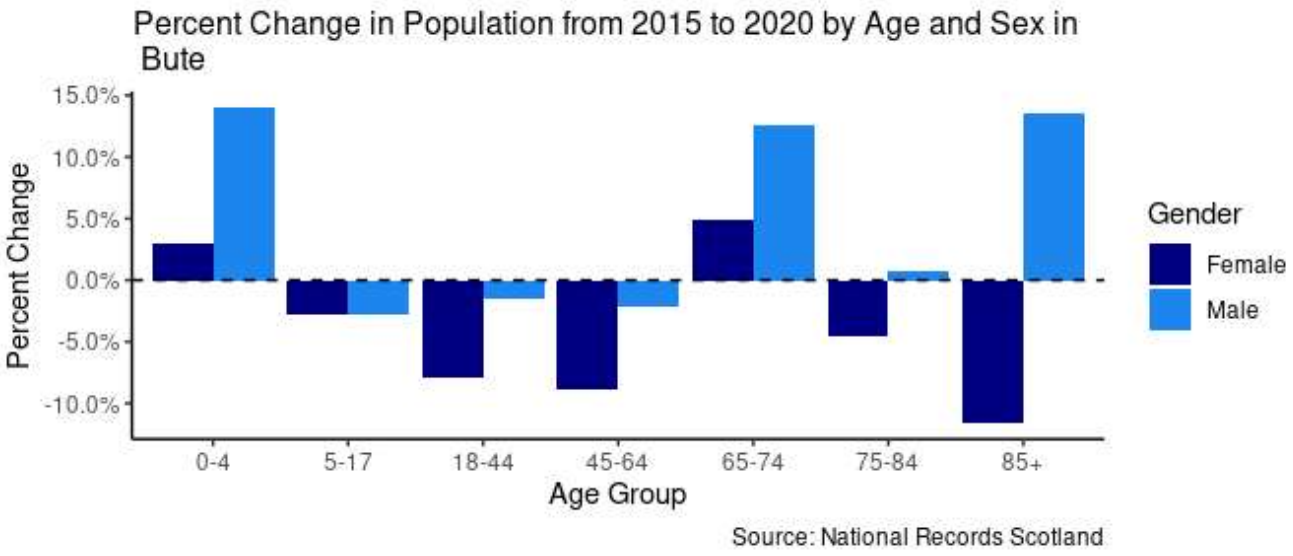
Figure 2: Population time trend and projection.



Source: National Records Scotland

Figure 3 shows how population structure has changed between 2015 and 2020.

Figure 3: Change in population structure over the last five years.



Deprivation

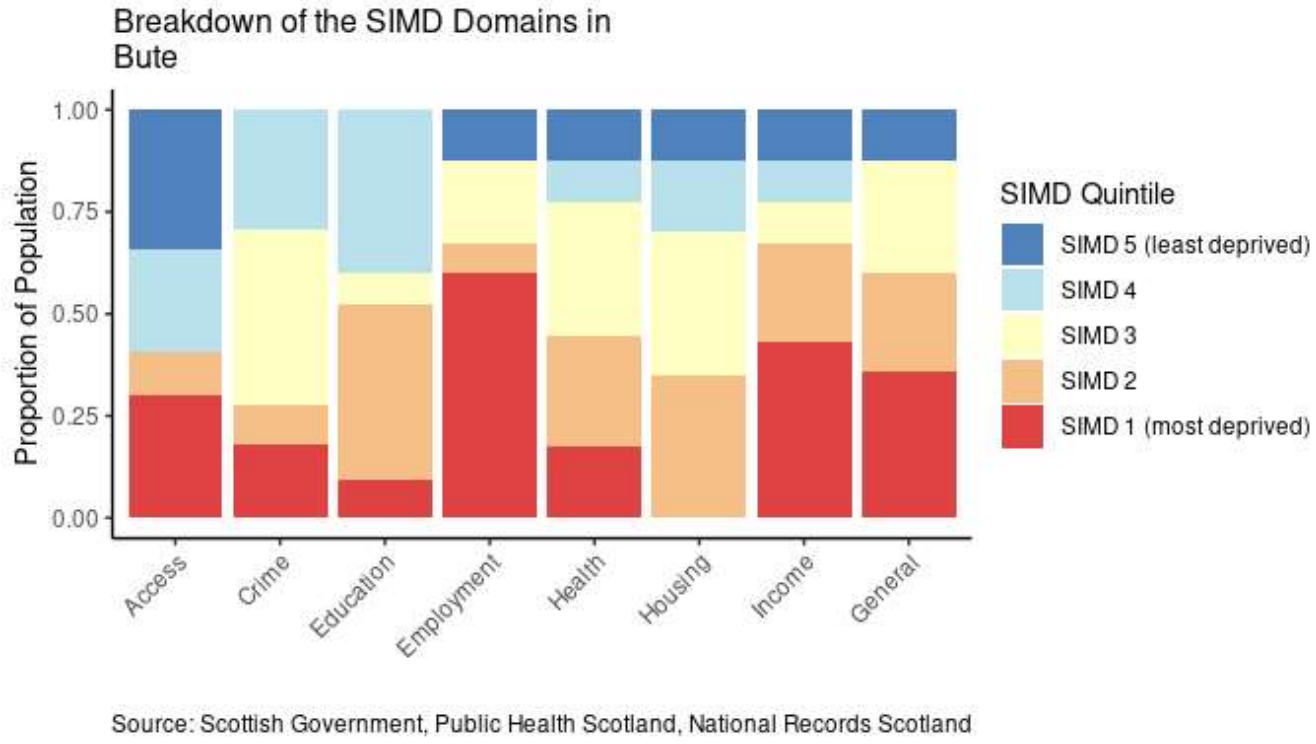
The following section explores the deprivation structure of Bute through the Scottish Index of Multiple Deprivation (SIMD). The SIMD ranks all datazones in Scotland by a number of factors; Access, Crime, Education, Employment, Health, Housing and Income. Based on these ranks, each datazone is then given an overall deprivation rank, which is used to split datazones into Deprivation Quintiles (Quintile 1 being the most deprived, and Quintile 5 the least). The most recent SIMD ranking was carried out in 2020. This section mainly focuses on the SIMD 2020 classifications, however the 2016 classifications are used to assess how deprivation has changed in Bute when compared to the rest of Scotland.

Of the 2020 population in Bute, **36%** live in the most deprived SIMD Quintile, and **12%** live in the least deprived SIMD Quintile. The following table details the percent of the population living in the 2016 SIMD Quintiles, the percent living in the 2020 SIMD Quintiles, and their difference for comparison.

Table 1: Percentage population living in the 2016 and 2020 SIMD Datazone Quintiles

Quintile	Percent of Pop (2016)	Percent of Pop (2020)	Difference
SIMD 1	17.3%	36.0%	18.7%
SIMD 2	49.1%	24.0%	-25.1%
SIMD 3	20.8%	27.5%	6.8%
SIMD 4	12.9%	0.0%	-12.9%
SIMD 5	0.0%	12.5%	12.5%

Figure 4: Proportion of the population that reside in each 2020 SIMD quintile by domain.



Source: Scottish Government, Public Health Scotland, National Records Scotland

Households

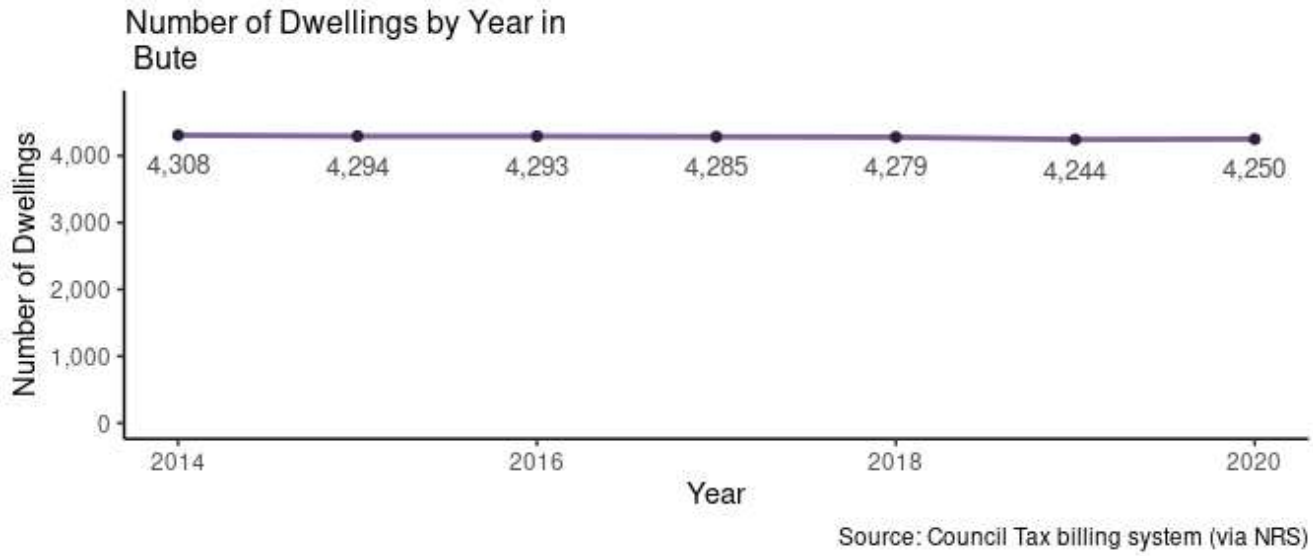
Summary:

For the most recent time periods available, Bute Locality had:

- **4,250** dwellings, of which: **81%** were occupied and **11%** were second homes.
- **36%** of dwellers received a single occupant council tax discount, and **1.8%** were exempt from council tax entirely.
- **81%** of houses were within council tax bands A to C, and **3.8%** were in bands F to H.

The graph below shows the number of dwellings in Bute from 2014 to 2020.

Figure 5: Number of dwellings time trend.



Of the total number of dwellings in 2020, 36% (1,544 households) were occupied by an individual receiving a single occupant council tax discount. Furthermore, 1.8% (75 households) were occupied and exempt from council tax.

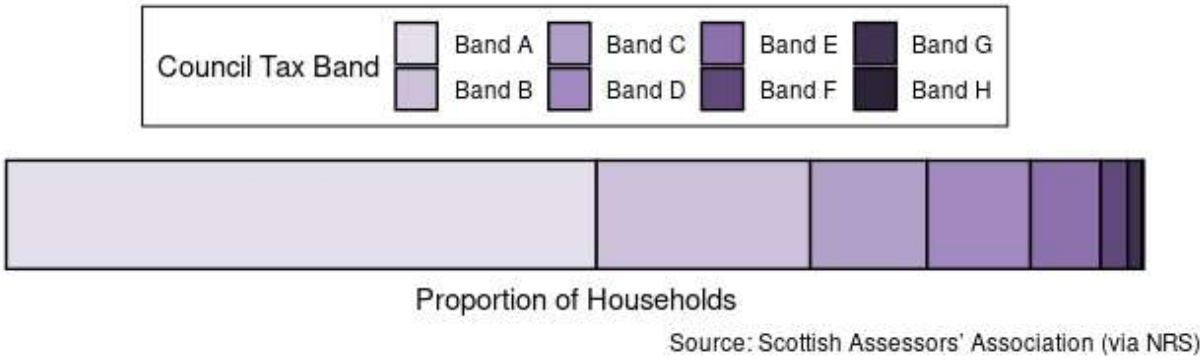
There were 455 dwellings classed as a second home in 2020, these dwellings made up 11% of the households in Bute.

Table 2: Breakdown of dwelling types by year for Bute locality.

Year	Total Dwellings	Occupied Dwellings	Vacant Dwellings	Single Occupant Tax Discount	Council Tax Exempt Dwellings	Second Homes
2014	4,308	3,489	331	1,555	58	488
2015	4,294	3,398	386	1,510	59	510
2016	4,293	3,388	392	1,492	55	513
2017	4,285	3,468	341	1,503	66	476
2018	4,279	3,443	369	1,470	62	466
2019	4,244	3,451	352	1,485	74	441
2020	4,250	3,450	347	1,544	75	455

The proportion of households within each council tax band are displayed in the chart below, figures are shown in Table 3.

Figure 6: Breakdown of households by council tax band for Bute in 2020.



Source: Scottish Assessors' Association (via NRS)

Table 3: Percentage of households by council tax band for Bute in 2020.

Tax Band	A	B	C	D	E	F	G	H
Percent of households	52%	19%	10%	9.1%	6.2%	2.4%	1.3%	0.14%

General Health

Summary:

For the most recent time periods available[3], Bute Locality had:

- **An average life expectancy of 75.4 years for males and 81.7 years for females.**
- **A death rate for ages 15 to 44 of 225 deaths per 100,000 age-sex standardised population[4]**
- **26%** of the locality's population with at least one long-term physical health condition.
- A cancer registration rate of **604** registrations per 100,000 age-sex standardised population[4]
- **22.45%** of the population being prescribed medication for anxiety, depression, or psychosis.

Life Expectancy

In the latest time period available from 2016-2020 (5 year aggregate), the average life expectancy in Bute locality was 75.4 years old for men, and 81.7 years old for women. A time trend since 2013-2017 can be seen in figure 8.

Figure 8: Average life expectancy in men and women over time.

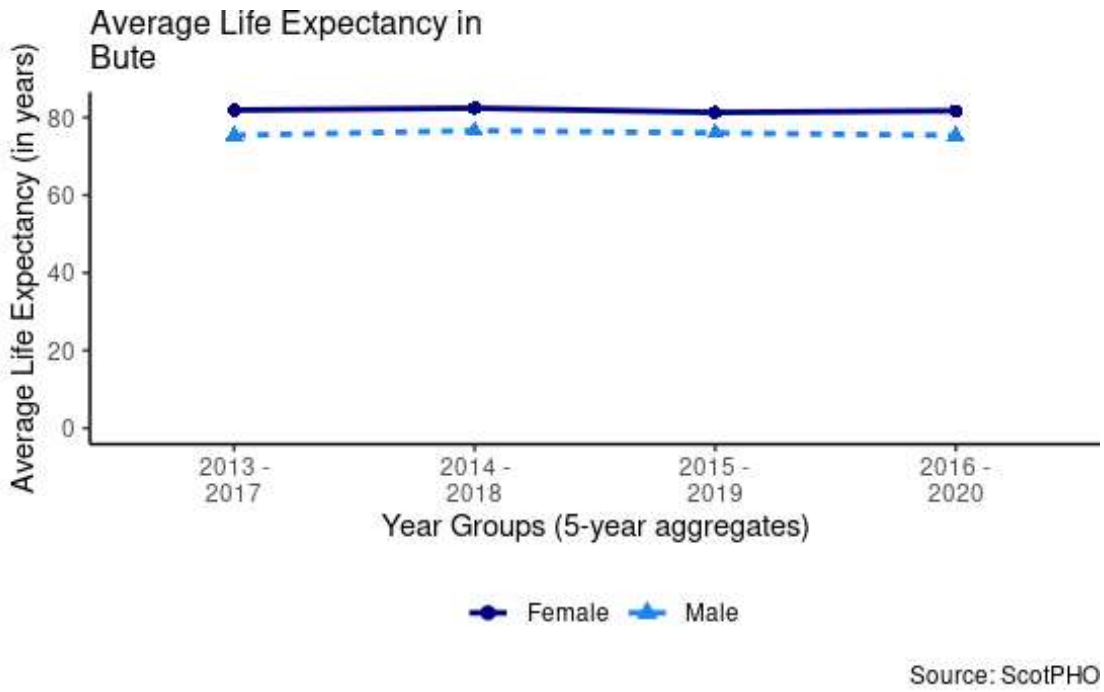


Table 5 provides the average life expectancy for men and women in different areas for the latest time period available. Please note that these are 5 year aggregates for the locality from 2016-2020, but 3 year aggregates from 2018-2020 at partnership, Health Board, and Scotland level.

Table 5: Average life expectancy in years for the latest time periods (2016-2020 aggregated years for the locality; 2018-2020 aggregated years for other areas).

	Locality	Partnership	Health Board	Scotland
	81.7	81.6	81.8	81
	75.4	78	77.6	76.8

Where Locality = Bute, Partnership = Argyll and Bute HSCP, Health Board = NHS Highland.

Deaths, aged 15-44

The following chart shows a trend of death rates among 15-44 year olds per 100,000 age-sex standardised population[4] by area (i.e. Early mortality rate per 100,000). In the most recent aggregate time period available (from 2018-2020), the mortality rate in Bute locality was **225** deaths per 100,000 population. Figure 10 then provides comparisons of deaths for all localities in Argyll and Bute HSCP, for the two latest time aggregates available.

Figure 9: Deaths aged 15-44 years by geographical area and over time.

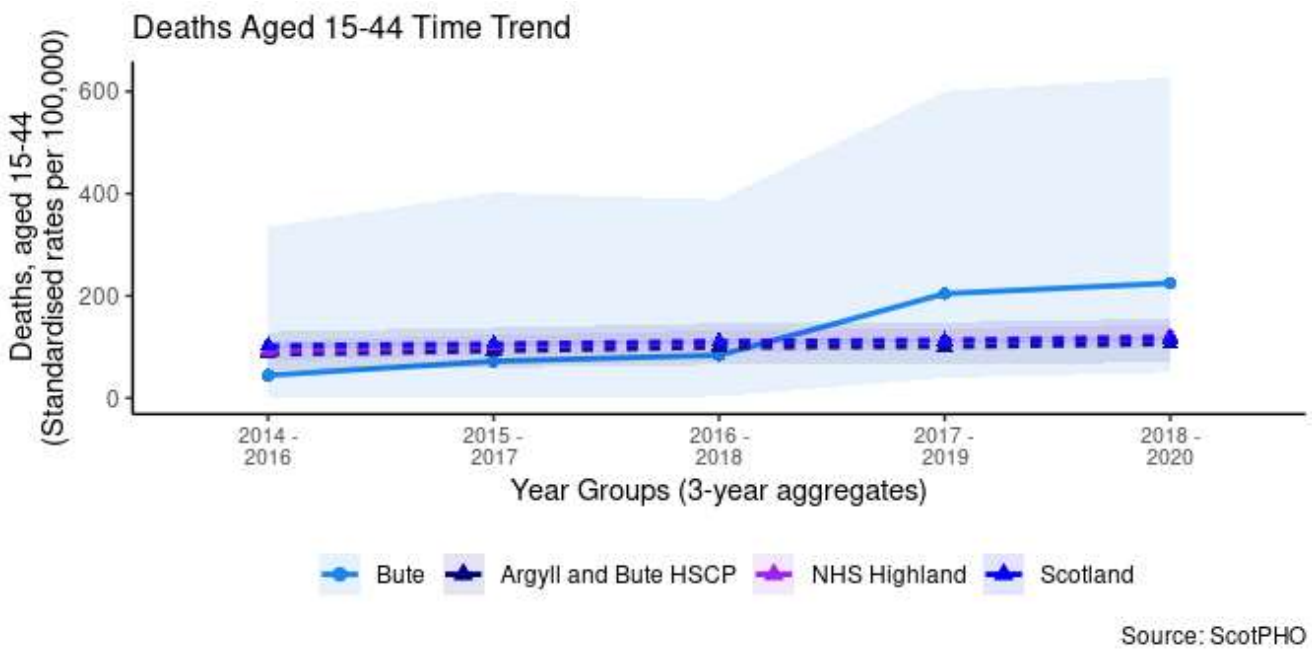
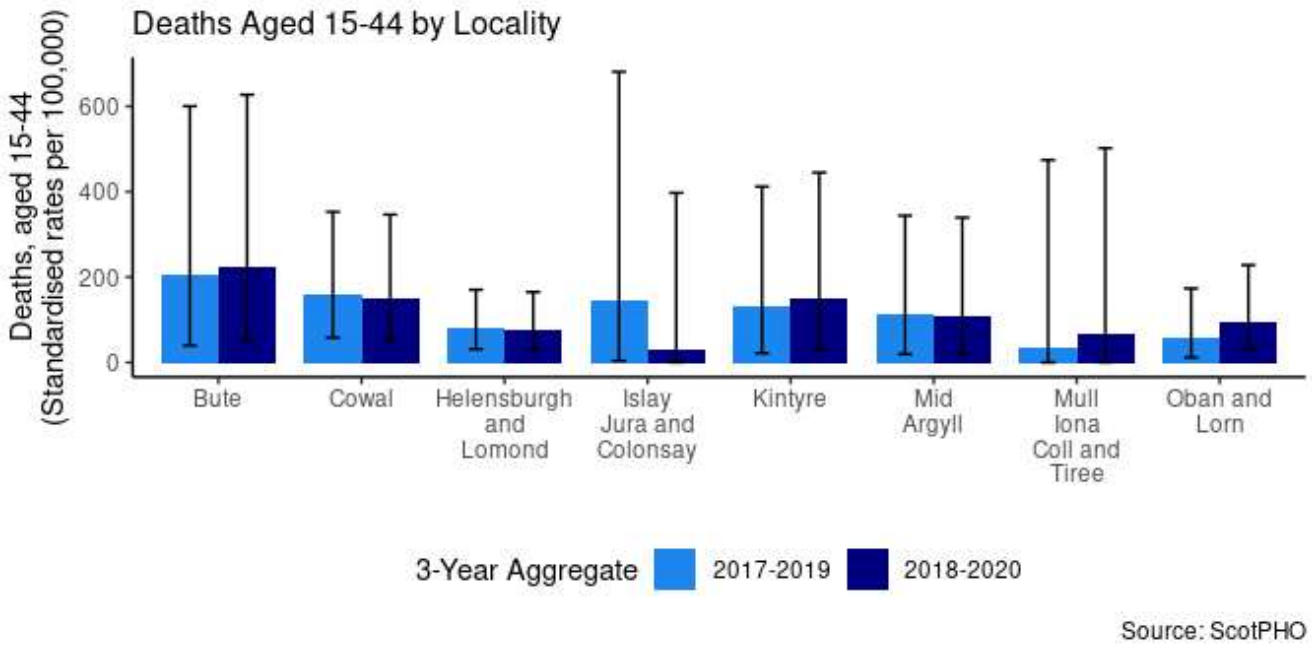
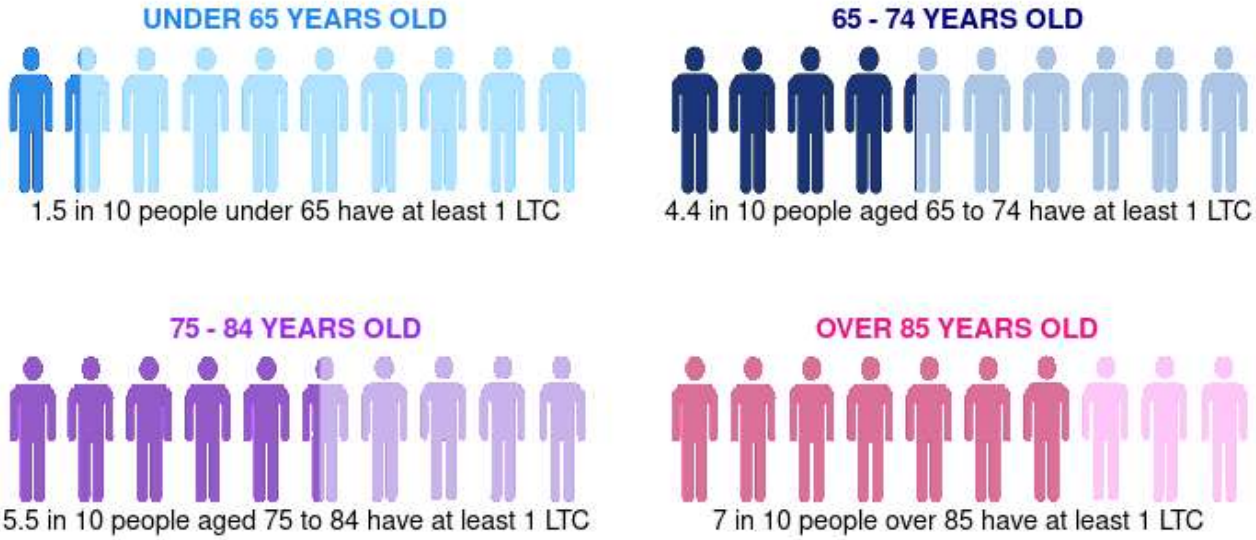


Figure 10: Deaths at ages 15-44 in Argyll and Bute HSCP localities.



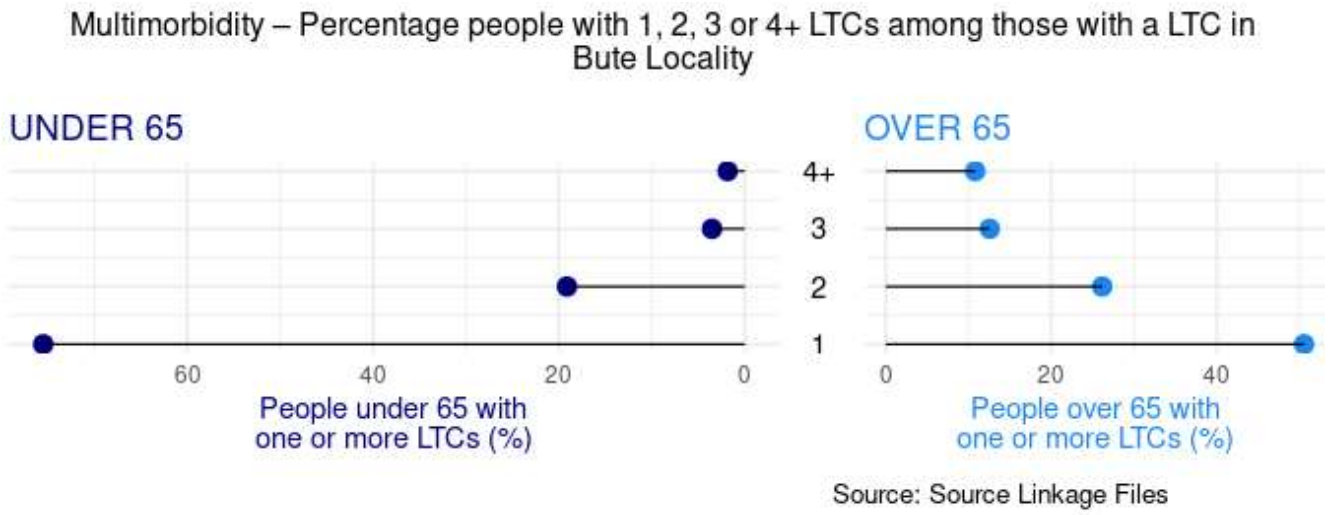
Long-Term Physical Health Conditions and Multimorbidity

In the financial year 2020/21, in Bute Locality, **26%** of the total population had at least one physical long-term condition (LTC). These include: cardiovascular, neurodegenerative, and respiratory conditions, as well as other organ conditions (namely liver disease and renal failure), arthritis, cancer, diabetes, and epilepsy. *Please see footnotes for information and caveats on identifying LTCs.*[5]



The co-occurrence of two or more conditions, known as multimorbidity, is broken down in figure 11, distinguishing between age groups. Note that this chart *excludes* the population in the locality who do not have any physical long-term conditions. Figure 13 therefore shows that among the people who have a LTC, **24**% of those under the age of 65 have more than one, compared to **49**% of those aged over 65.

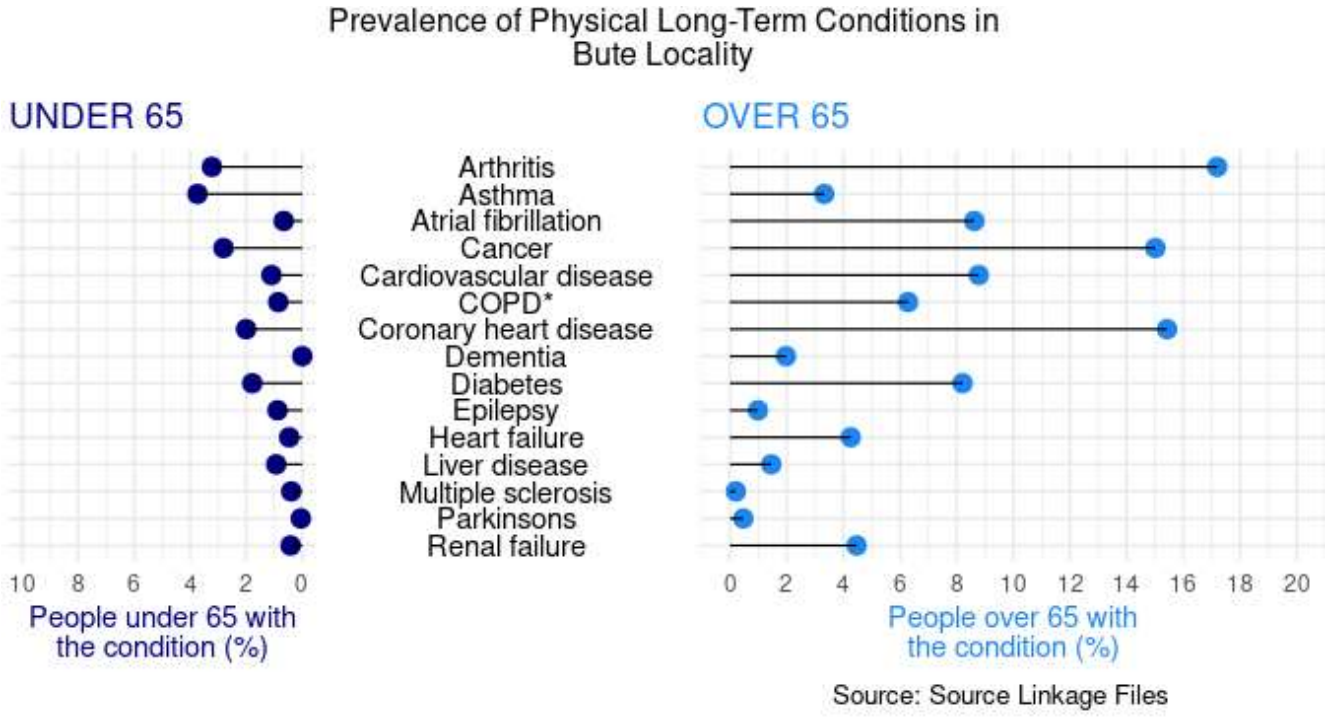
Figure 11: Multimorbidity of physical long-term conditions by age group in 2020/21.



Most common physical Long-Term Conditions (LTCs)

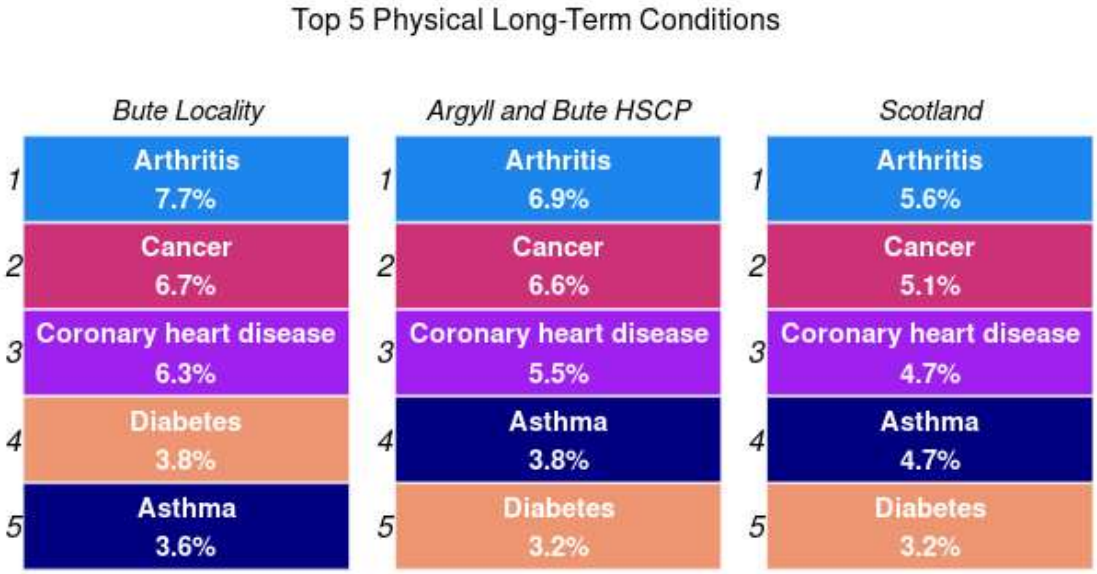
Below is a breakdown of the physical LTCs, for the financial year 2020/21. Figure 12 shows the prevalence of different LTCs in each age group in Bute locality, and Table 6 illustrates the top 5 physical LTCs across all ages at locality, partnership, and Scotland level.

Figure 12: Percentage people with each physical LTC, split by age group.



COPD: Chronic Obstructive Pulmonary Disease

Table 6: Prevalence of the five most common physical LTCs as a percentage of the population across geographical areas (where 1 = most prevalent).



Cancer Registrations

For the period 2017-2019, there were 51 new cancer registrations per year on average (**604** registrations per 100,000 age-sex standardised population) in Bute locality. This is a **3.1%** decrease in cancer registrations rate from the previous aggregate period 2016-2018. Figure 13 shows changes over time since 2014-2016, and Figure 14 compares the rates of localities in Argyll and Bute HSCP for the two latest available time periods.

Figure 13: Cancer registration rate over time and by geographical area.

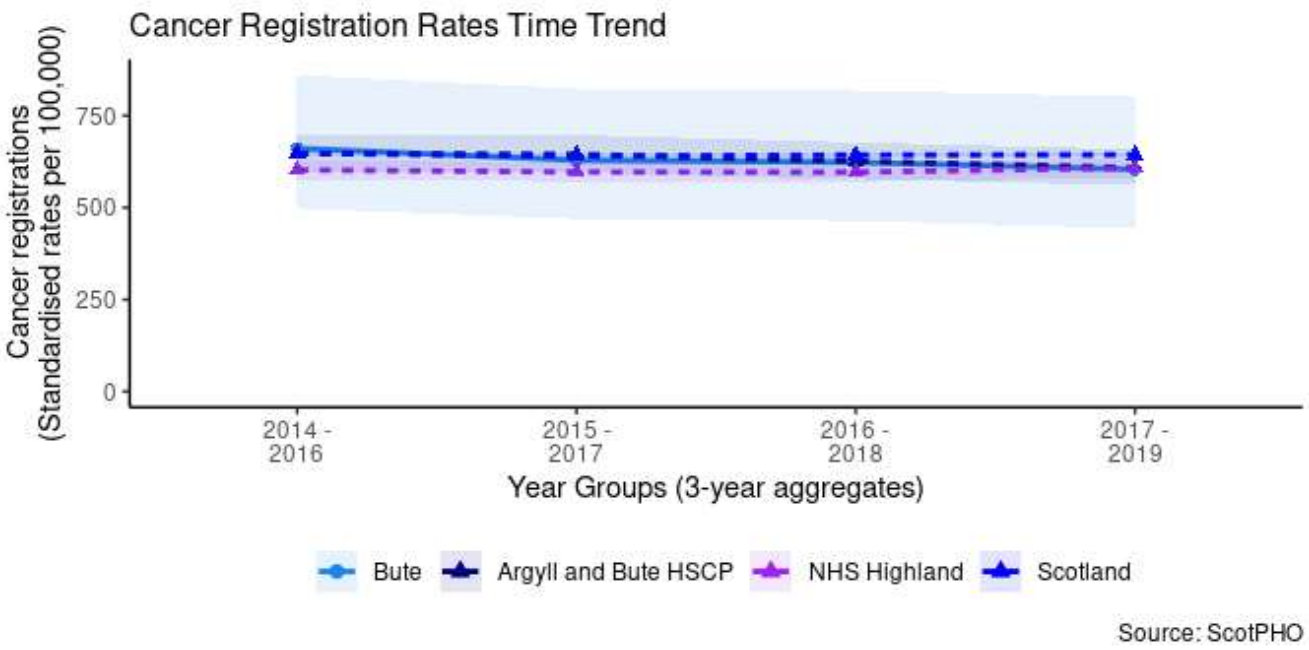
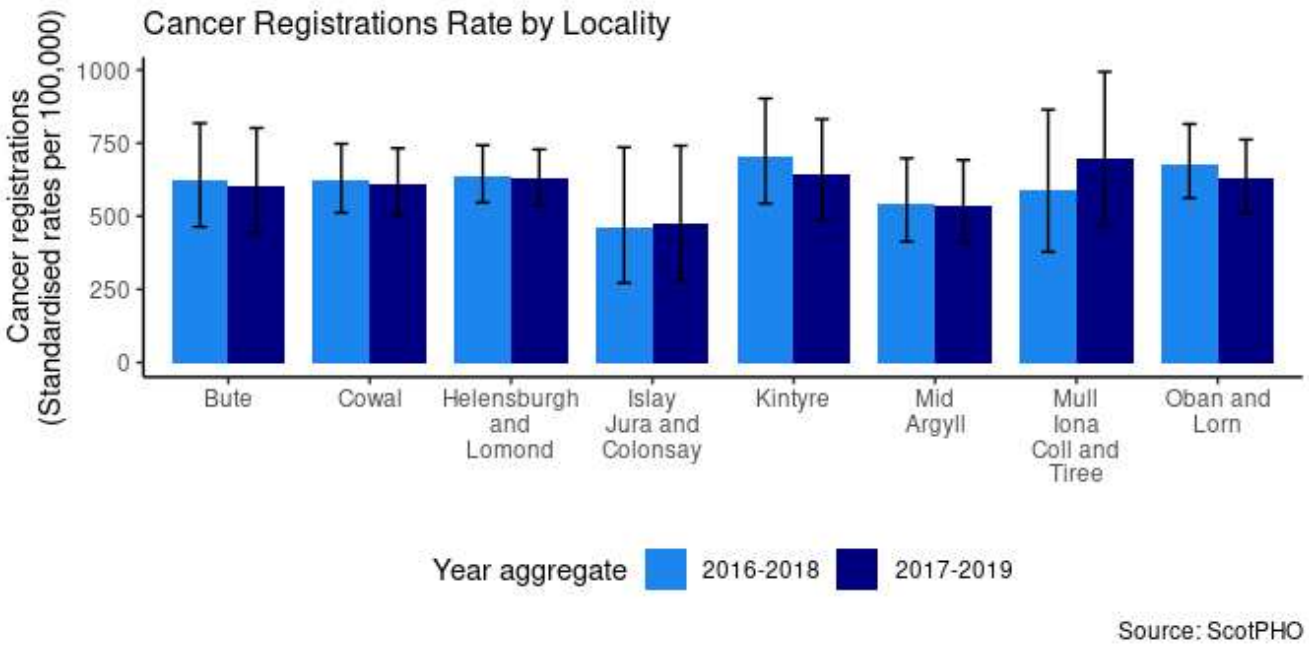


Figure 14: Cancer registration rates in Argyll and Bute HSCP localities.



Anxiety, Depression, and Psychosis Prescriptions

In the 2019/20 financial year, 22.45% of people were prescribed medication for anxiety , depression, or psychosis (ADP) in Bute Locality. This is a 0.13% increase from the previous financial year. Differences over time and between areas may relate to multiple factors, only one of which is underlying disease. Note that data are based on main original licensed use for the prescriptions and some drugs included may be prescribed for other purposes.

Figure 15: Percentage population prescribed ADP medication in Argyll and Bute HSCP localities.

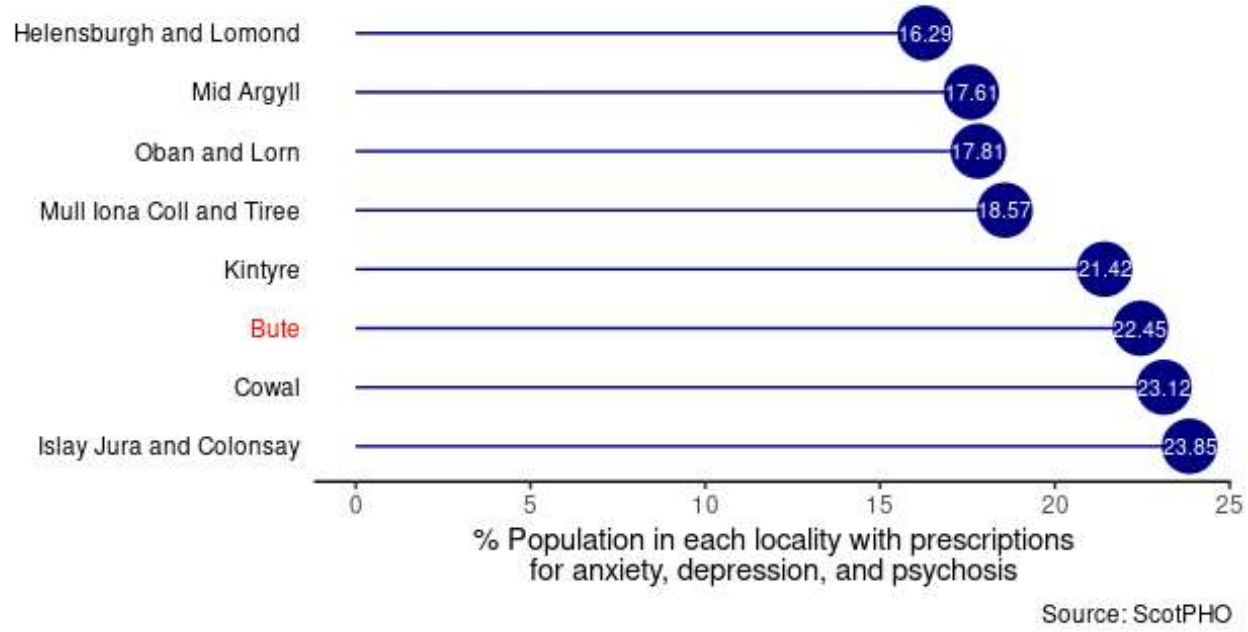
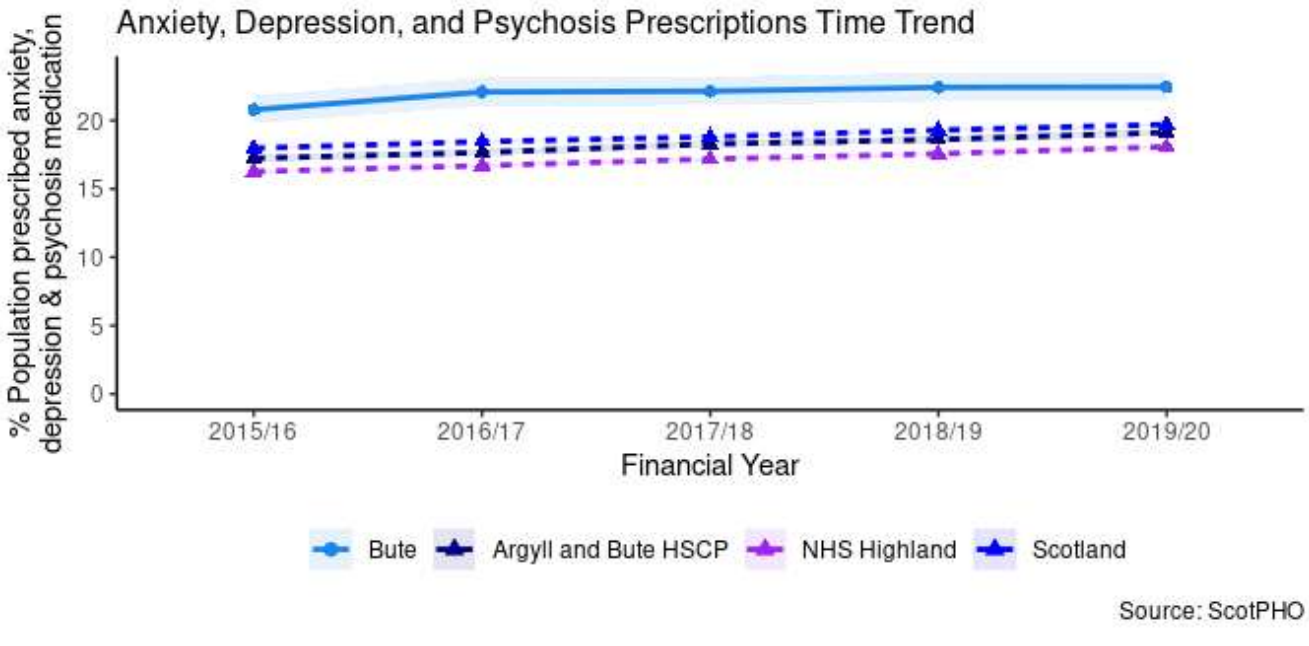


Figure 16: ADP prescriptions over time and by geographical area.



Behavioural Factors

Summary:

Mental and physical wellbeing has close ties with people's behaviours. Life circumstances including financial security, employment and location are interlinked with behavioural factors. This section provides data on drug-related hospital admissions, alcohol-related hospital admissions, alcohol-specific mortalities and bowel screening uptake, to give an overview of some behaviours known to be associated with health and wellbeing outcomes.

For the most recent time periods available[3], Bute had:

- **122** drug-related hospital admissions per 100,000 age-sex standardised population[4]. This is a lower rate of admissions than for Scotland (221).
- **623** alcohol-related hospital admissions per 100,000 age-sex standardised population[4].
- **22** alcohol-specific mortalities per 100,000 age-sex standardised population[4].
- a **59%** uptake of bowel cancer screening for the eligible population.

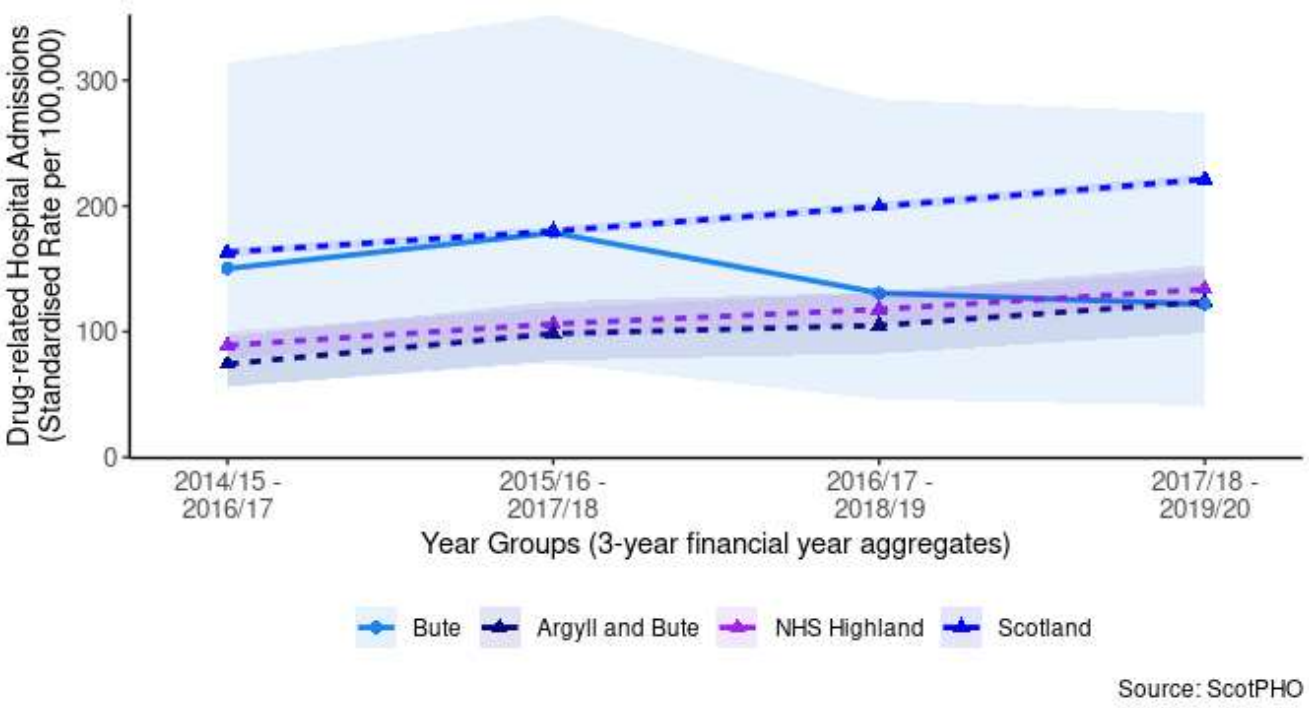
Drug-related Hospital Admissions

There were 122 drug-related hospital admissions per 100,000 age-sex standardised population[4] in Bute locality for the most recent time period available (3 year financial year aggregate for 2017/18 - 2019/20).

This is a -19% decrease since 2014/15 - 2016/17 (3 financial year aggregates).

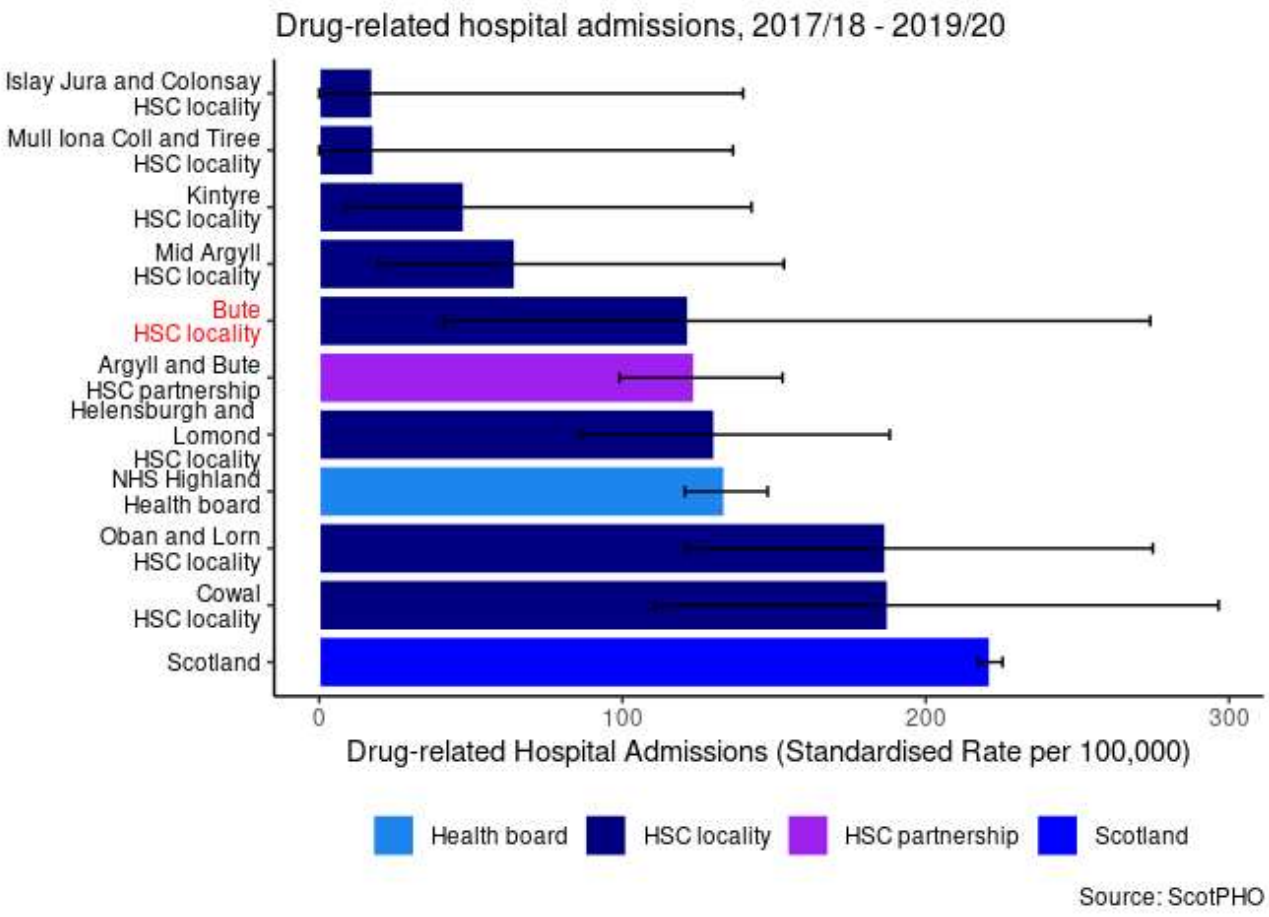
A trend of the change in drug-related hospital admissions for Bute locality compared with Scotland, Argyll and Bute HSCP and NHS Highland is shown in the chart below from 2014/15 - 2016/17 onwards.

Figure 17: Trend of Drug-related Hospital Admission Rates by geographical area.



A comparison of areas at the most recent time period (2017/18 - 2019/20 aggregated financial years) is available below. This shows Bute locality has a lower rate of admissions (122) than Argyll and Bute Partnership (124), and a lower rate of admissions than Scotland (221) overall.

Figure 18: Comparison of Drug-related Hospital Admission Rates for the period 2017/18 - 2019/20.

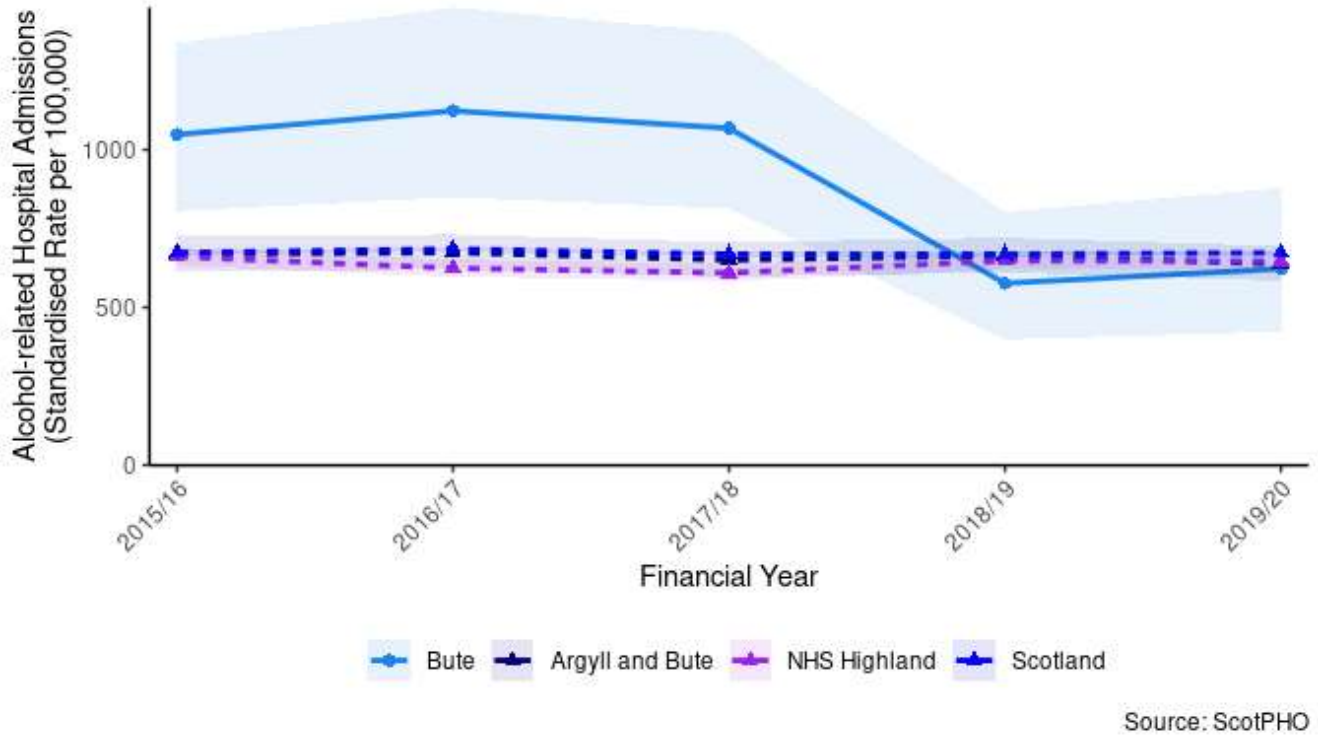


Alcohol-related Hospital Admissions

The 2019/20 alcohol-related admissions rate is 623 per 100,000 age-sex standardised population[4], which is a 41% decrease overall since 2015/16.

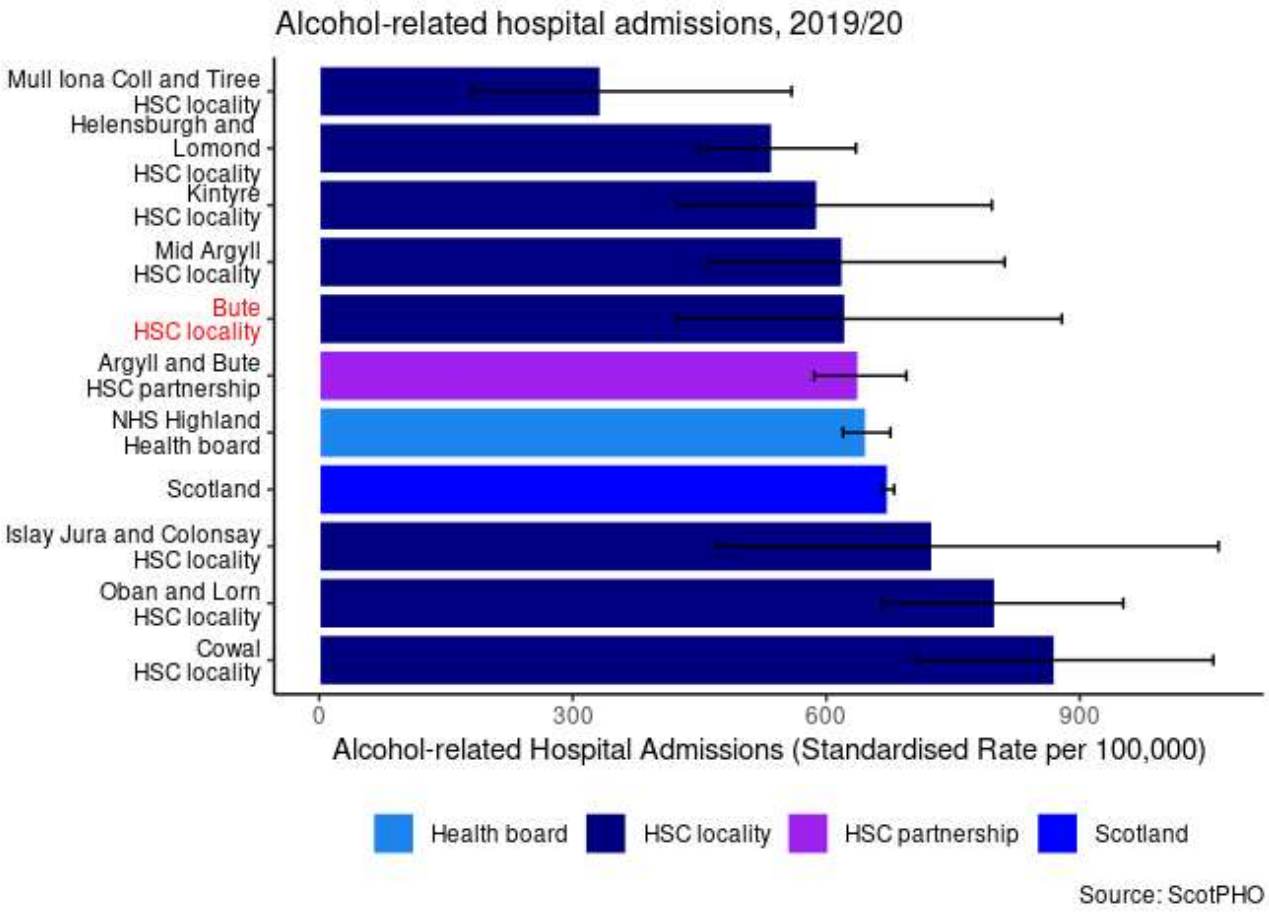
The chart below shows a trend of alcohol-related hospital admissions for Bute locality compared with Scotland, Argyll and Bute Partnership and NHS Highland from financial year 2015/16 to 2019/20.

Figure 19: Trend of Alcohol-related Hospital Admission Rates by geographical area.



Comparison across different areas for 2019/20 is shown in Figure 20. This shows that Bute locality had a lower alcohol-related hospital admissions rate (623) compared to Scotland (673).

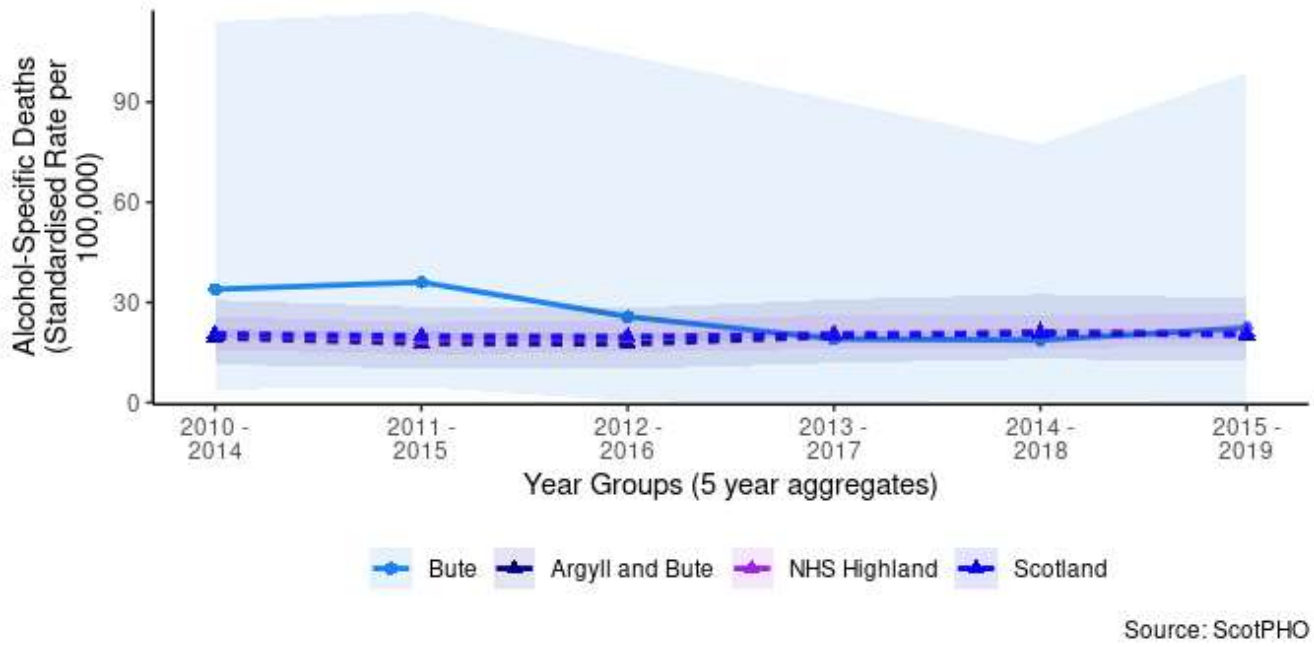
Figure 20: Comparison of Alcohol-related Hospital Admission Rates for 2019/20.



Alcohol-Specific Deaths

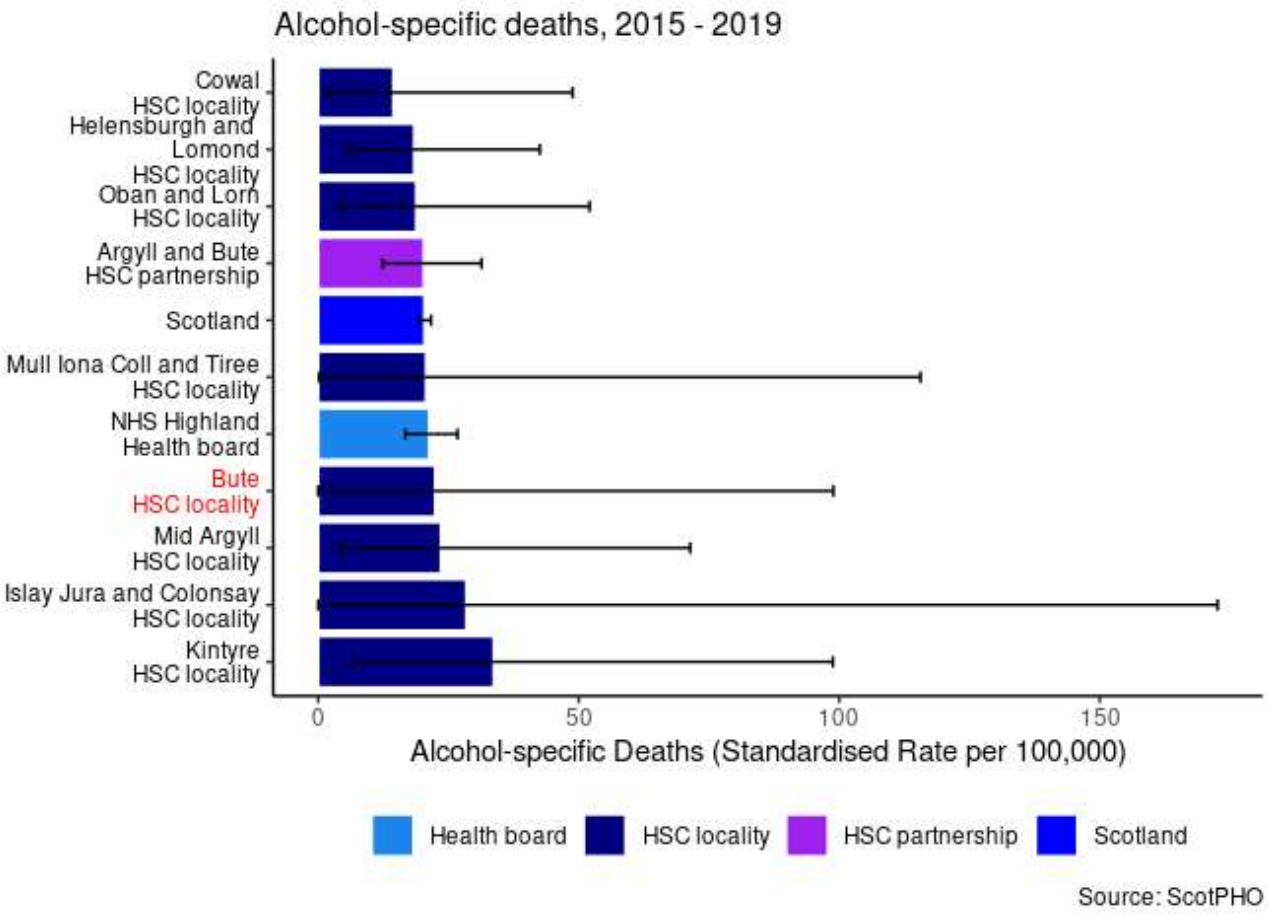
Data on alcohol-specific deaths is available as 5 year aggregates. The rate of alcohol-specific deaths is currently lower in Bute than the rate in 2010 - 2014 (-34% change).

Figure 21: Trend of Alcohol-Specific Death Rates by geographical area.



A comparison across different areas illustrates that Bute locality has a higher alcohol-specific death rate compared to Scotland as a whole.

Figure 22: Comparison of Alcohol-related Death Rates for the period 2015 - 2019 (5 year aggregate).

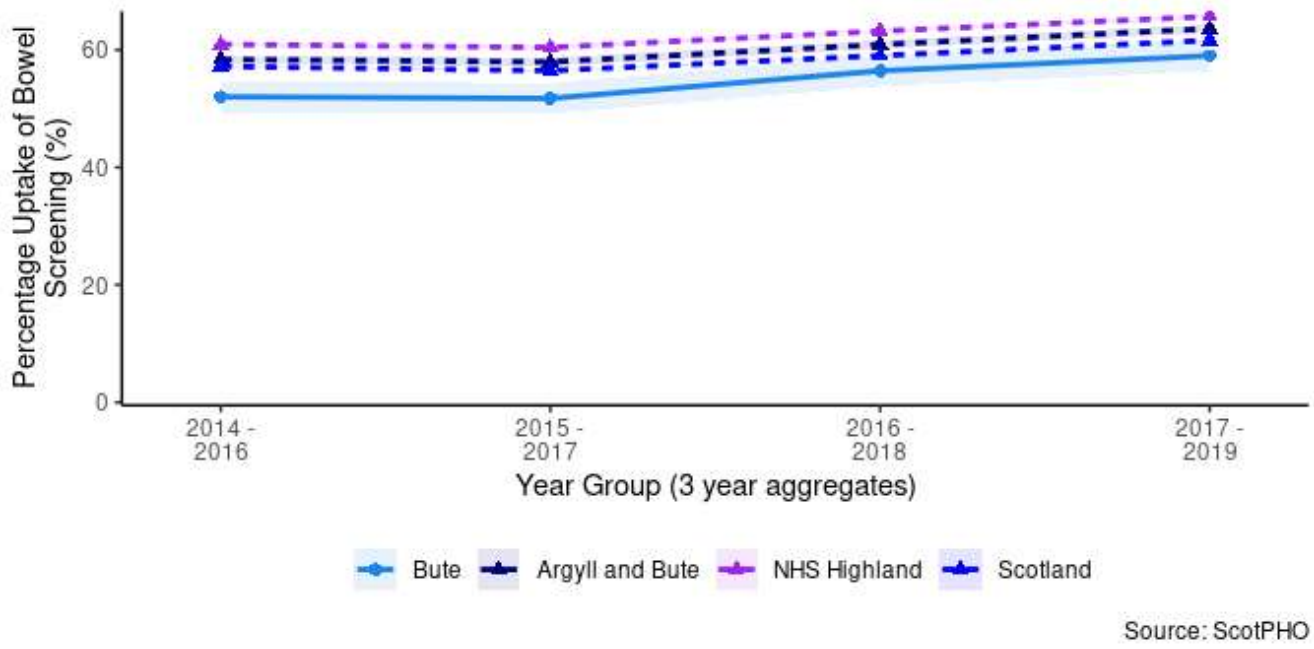


Bowel Screening Uptake

Bowel screening is offered every two years to eligible men and women aged between 50-74 years old. Eligible people are posted a test kit which is completed at home. Since 1st April 2013, those aged 75 and over can also self-refer and opt into screening.

A trend of the percentage uptake of bowel screening among the eligible population is shown below for Bute locality compared with Scotland, Argyll and Bute HSCP and NHS Highland. Data is suppressed into 3 year aggregates. The 2017 - 2019 uptake rate for Bute is **59%**.

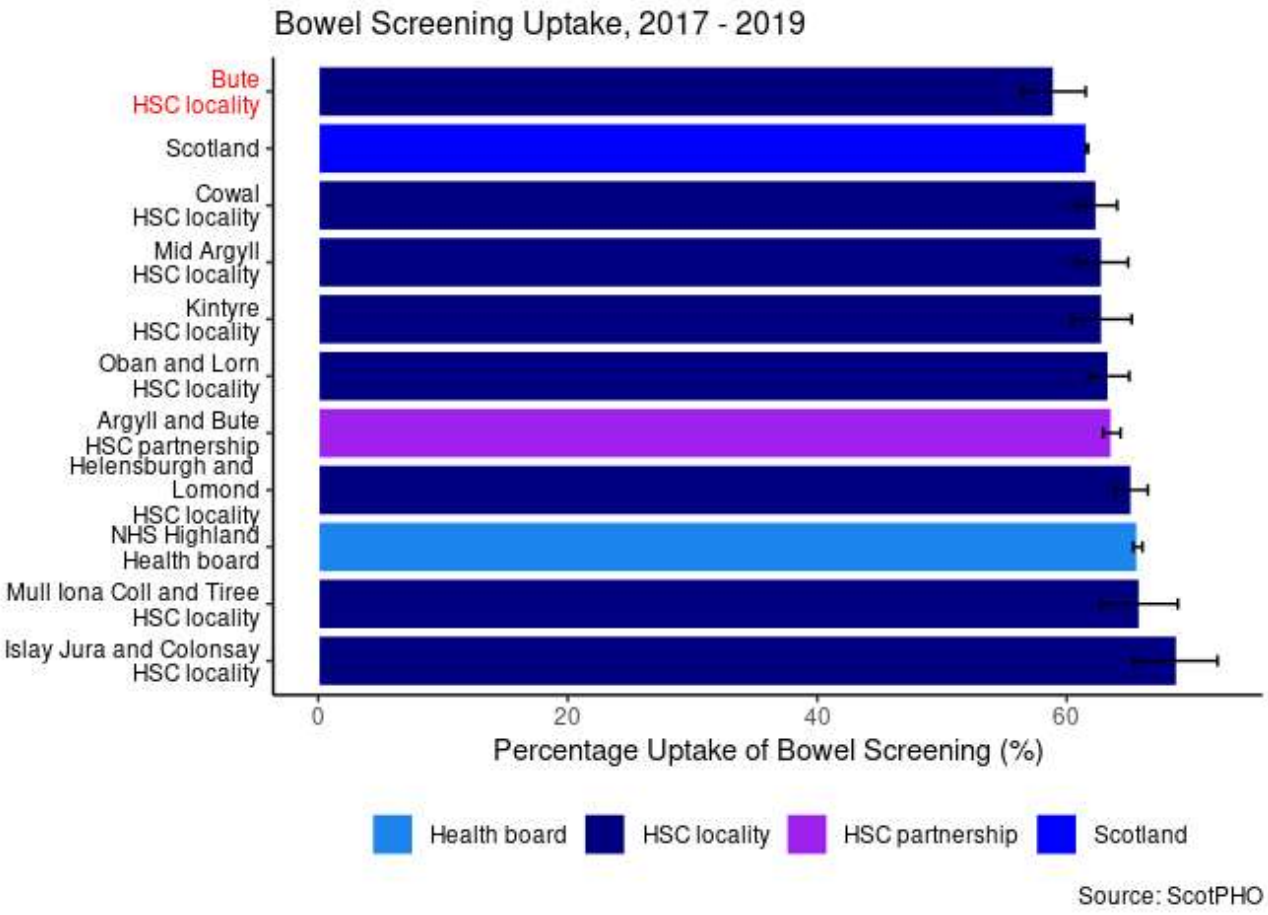
Figure 23: Trend of Bowel Screening Uptake for eligible men and women, by geographical area.



Source: ScotPHO

Compared with Scotland, Bute locality has a lower percentage uptake of bowel cancer screening for the period 2017 - 2019.

Figure 24: Comparison of Bowel Screening Uptake for 2017 - 2019.



Hospital and Community Care

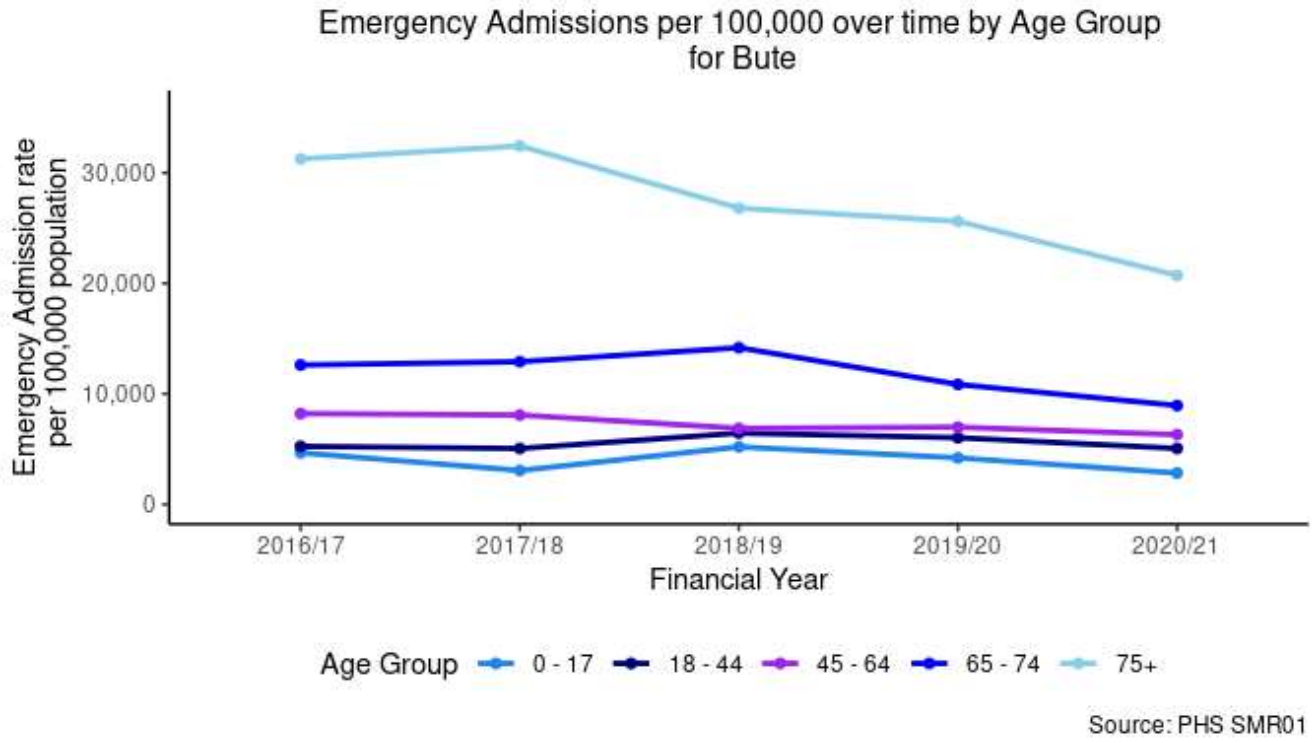
This section includes acute hospital data, delayed discharge bed days and A&E attendances. Please note that for 2020 onwards, hospital activity would have been severely affected by the COVID-19 pandemic. Information on how this has had a wider impact is provided in Footnote 6 at the end of the document.

For the most recent time periods available, Bute had:

- **8,002** emergency hospital admissions per 100,000 population.
- **66,338** unscheduled acute specialty bed days per 100,000 population.
- **3,508** A&E attendances per 100,000 population.
- **4,162** delayed discharge bed days per 100,000 population.
- **936** emergency hospital admissions from falls per 100,000 population.
- **70** emergency readmissions (28 day) per 1,000 discharges.
- **952** potentially preventable hospital admissions per 100,000 population.
- People on average spent **94%** of their last 6 months of life in a community setting.

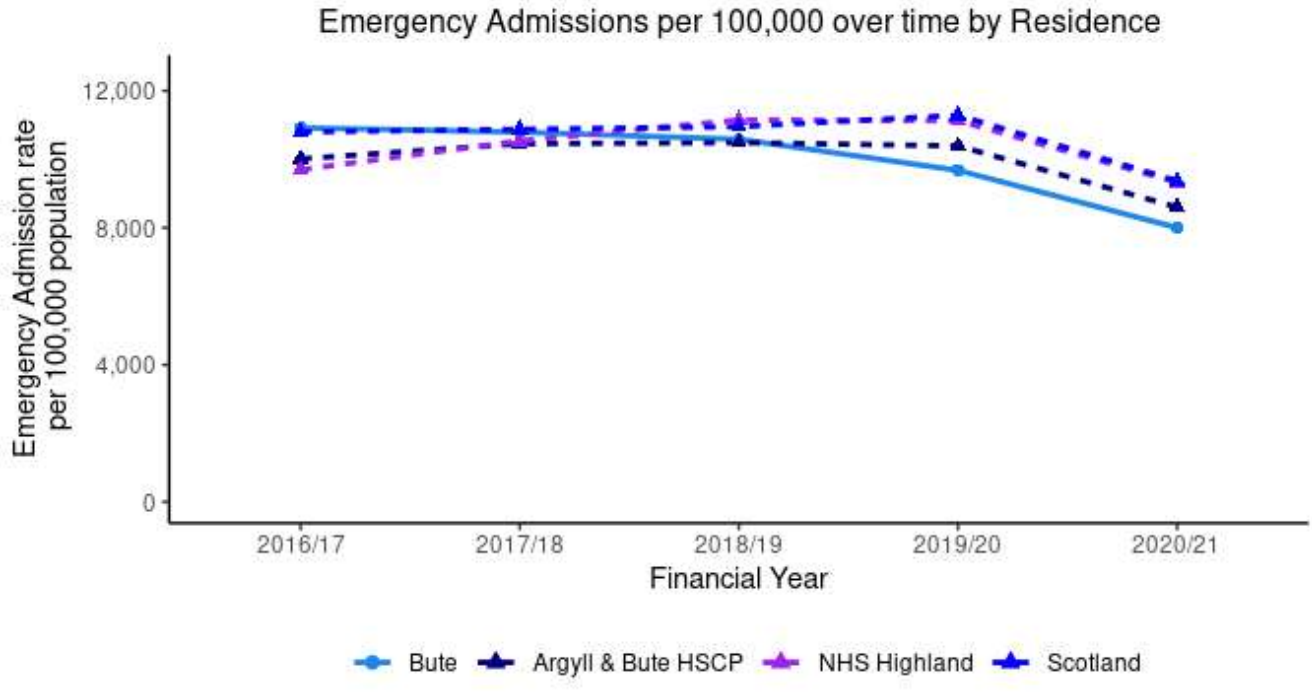
Emergency Admissions

Figure 25: Emergency admissions by age group



Source: PHS SMR01

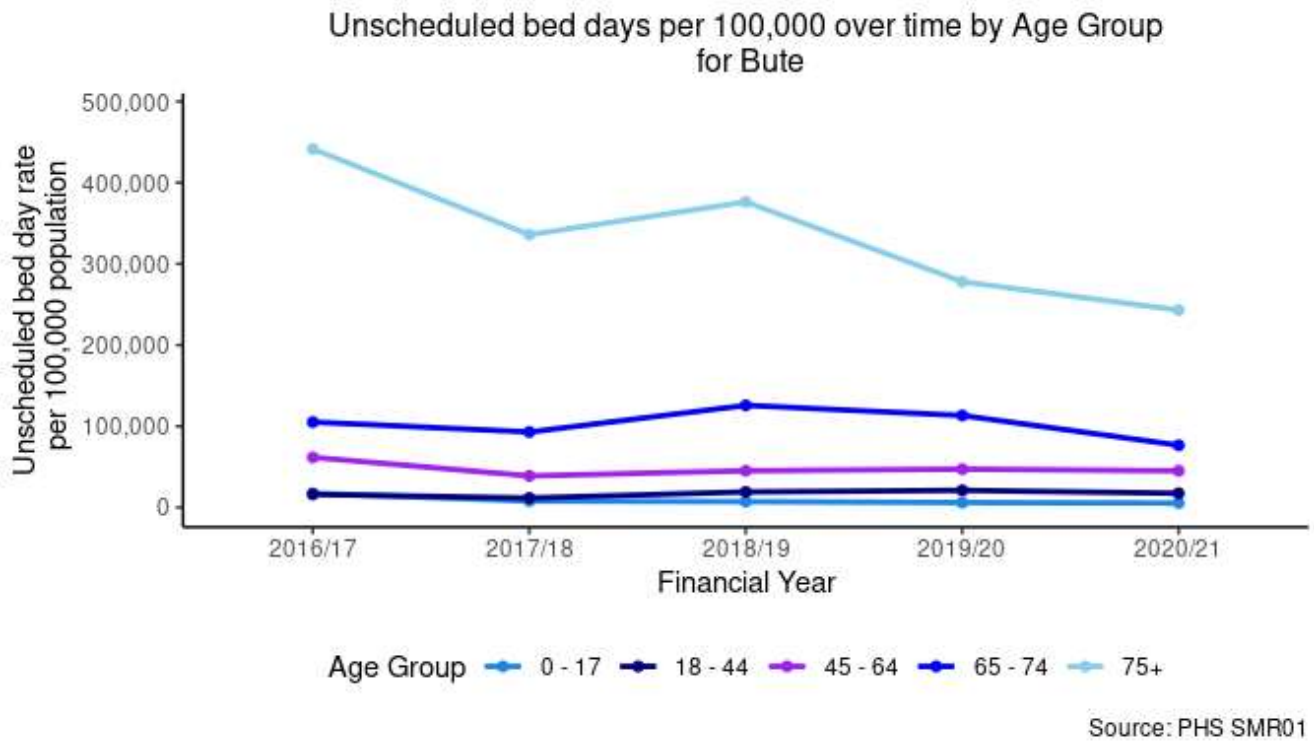
Figure 26: Emergency admissions by geographical area



Source: PHS SMR01

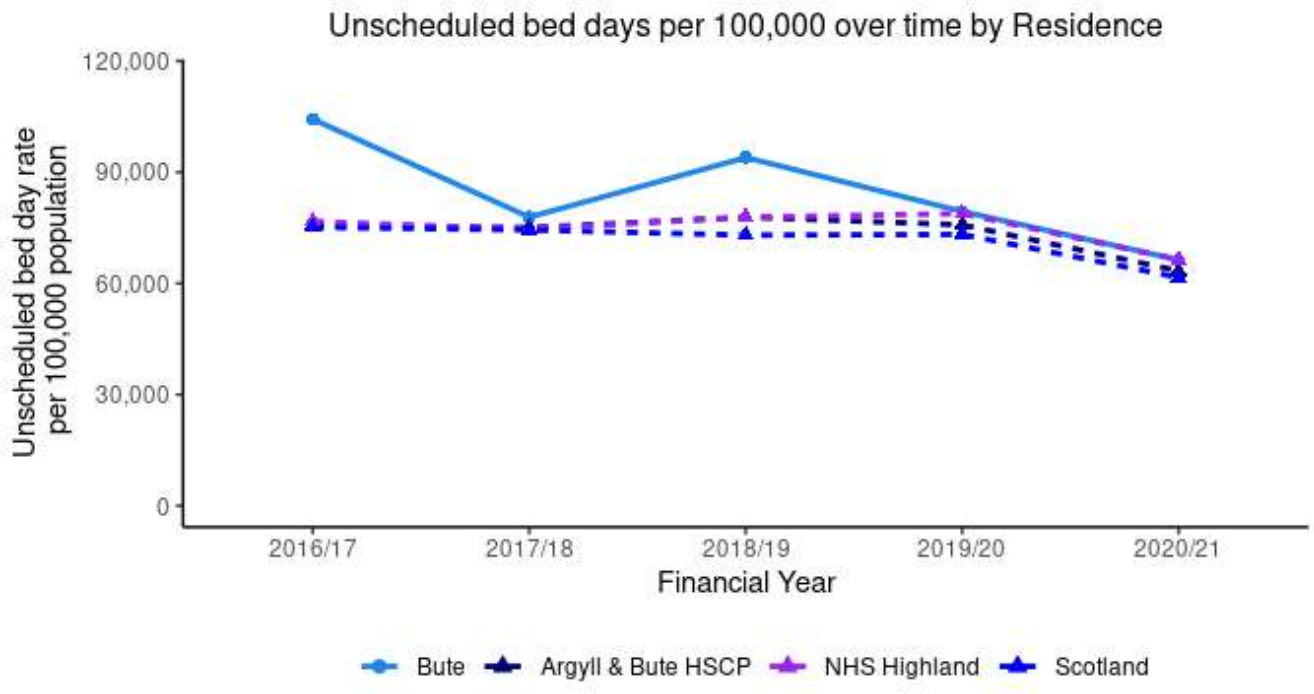
Unscheduled Acute Bed Days

Figure 27: Unscheduled bed days by age group



Source: PHS SMR01

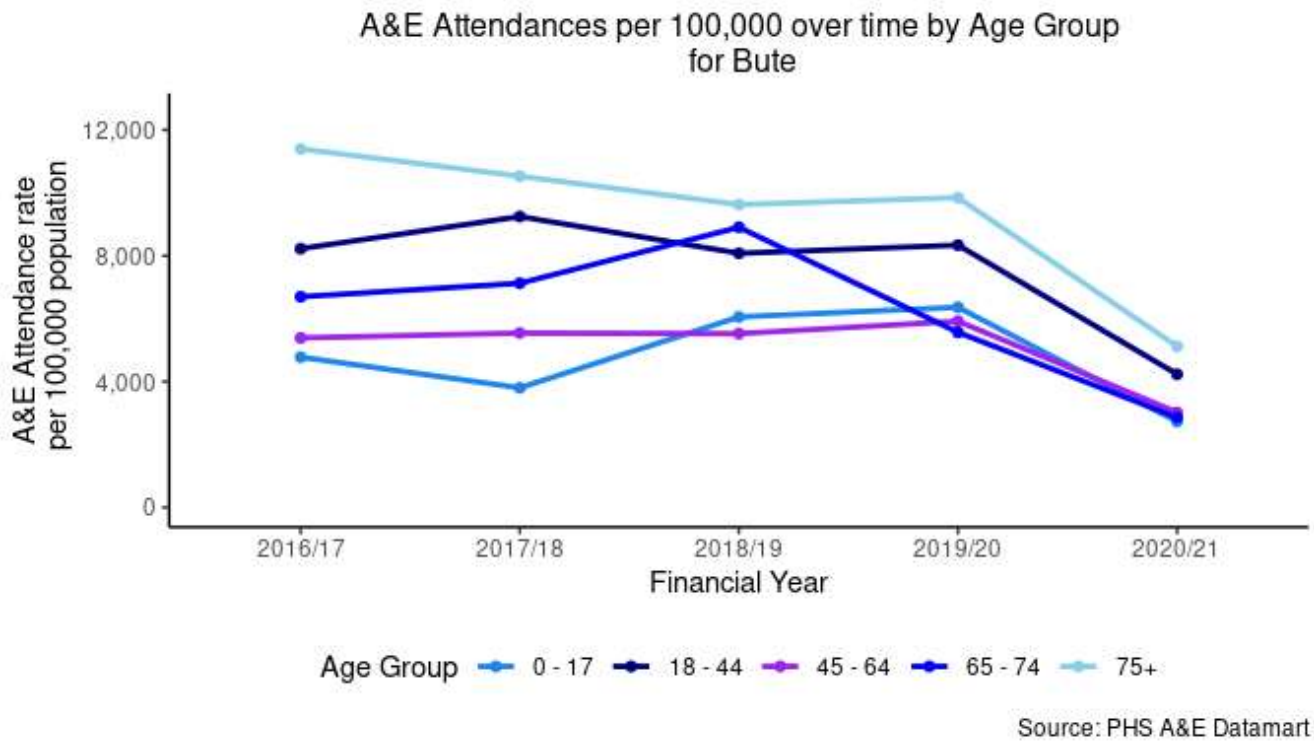
Figure 28: Unscheduled bed days by geographical area



Source: PHS SMR01

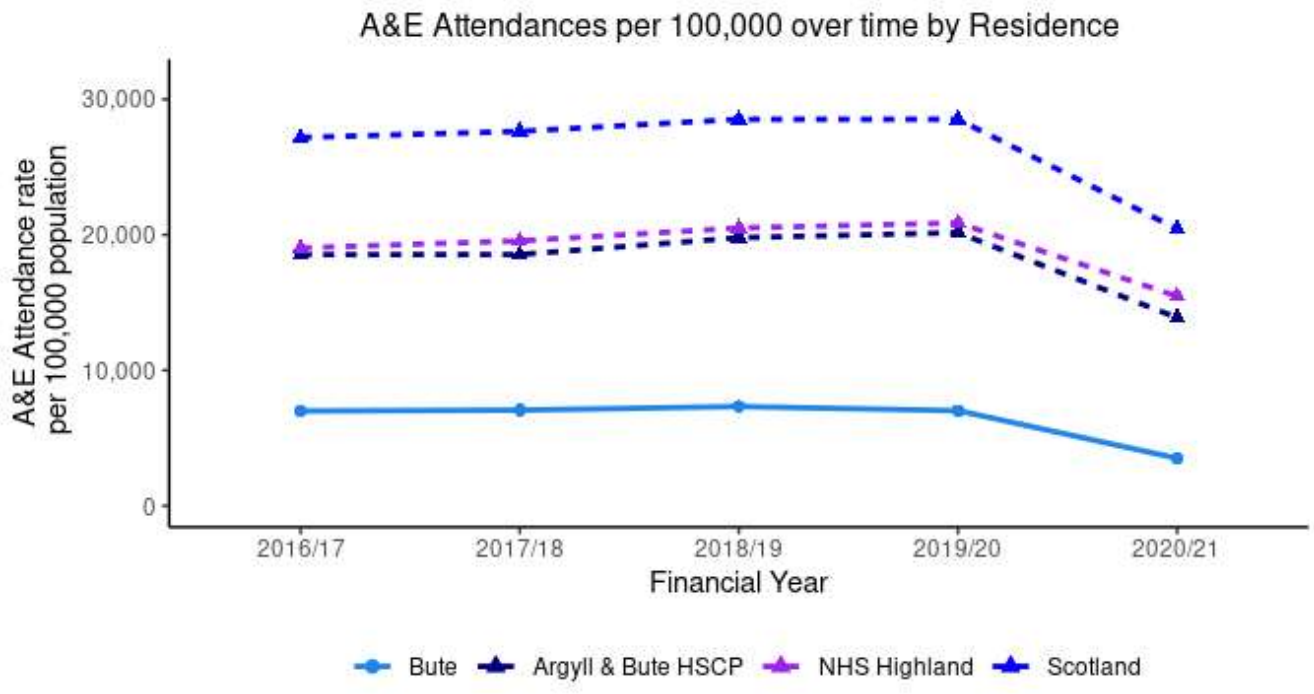
A&E Attendances

Figure 29: A&E attendances by age group



Source: PHS A&E Datamart

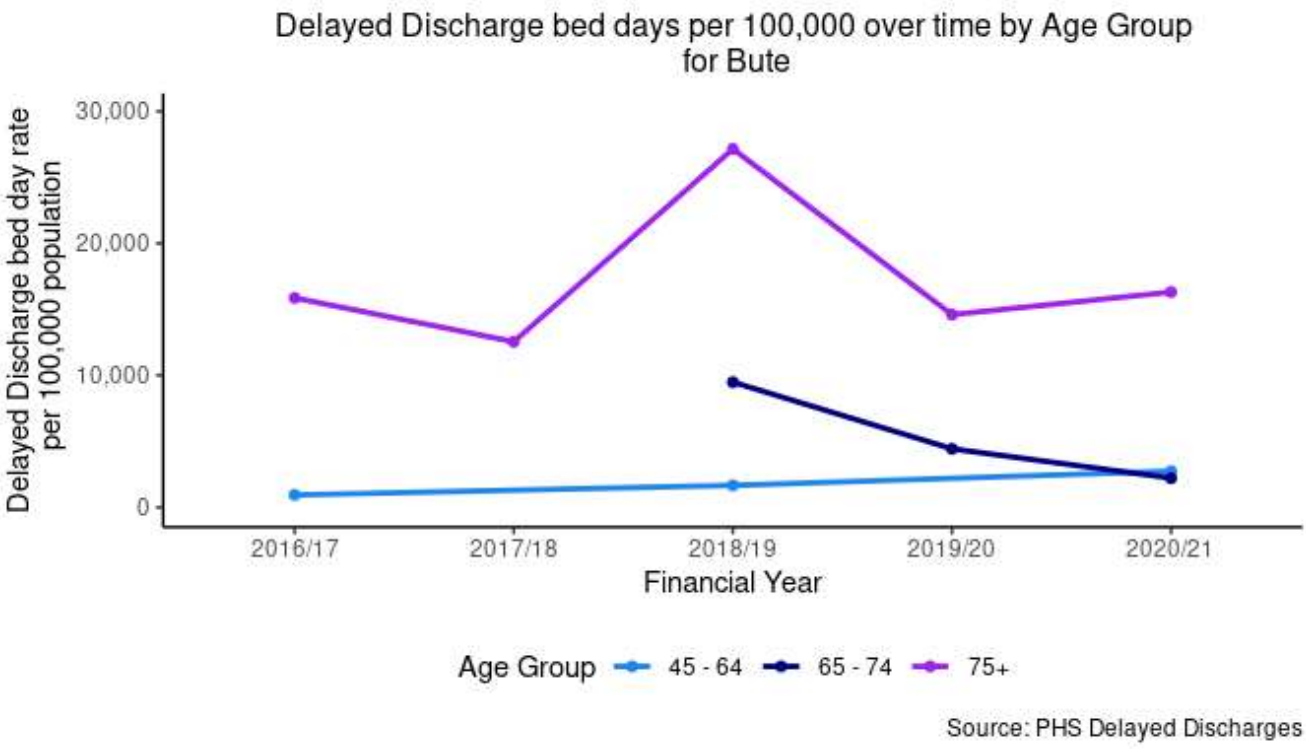
Figure 30: A&E attendances by geographical area



Source: PHS A&E Datamart

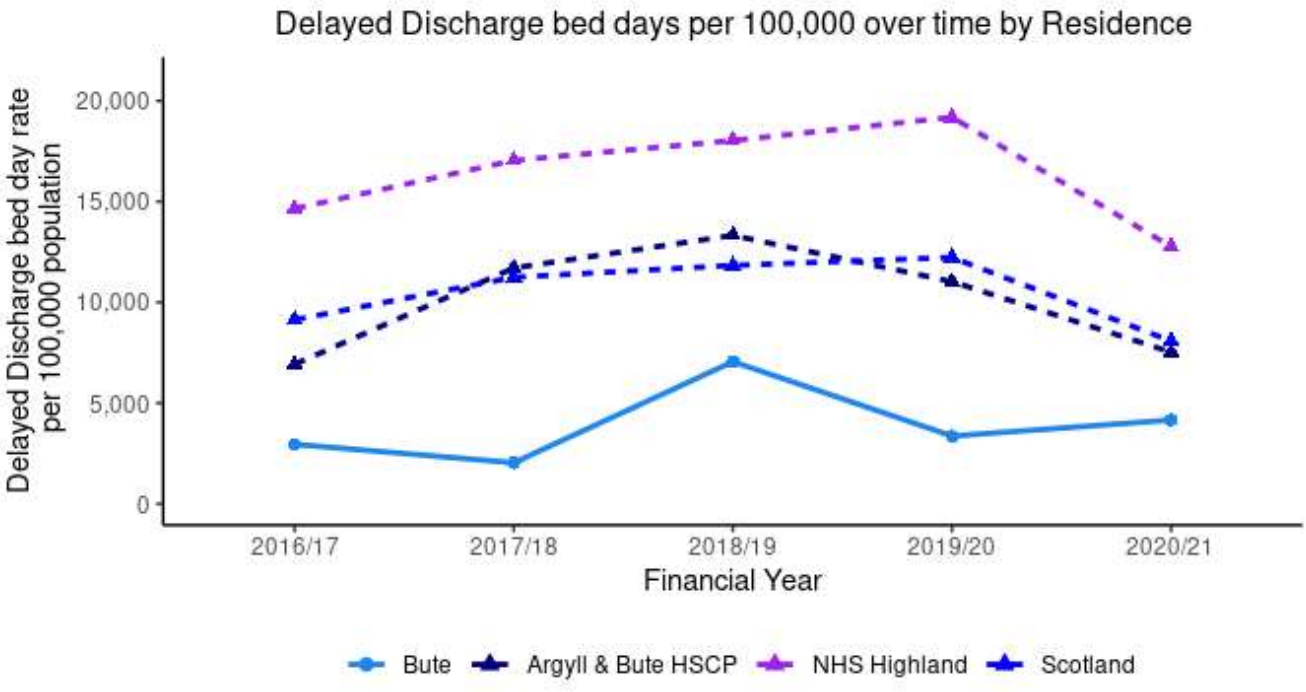
Delayed Discharge Bed Days

Figure 31: Delayed discharge bed days by age group



Source: PHS Delayed Discharges

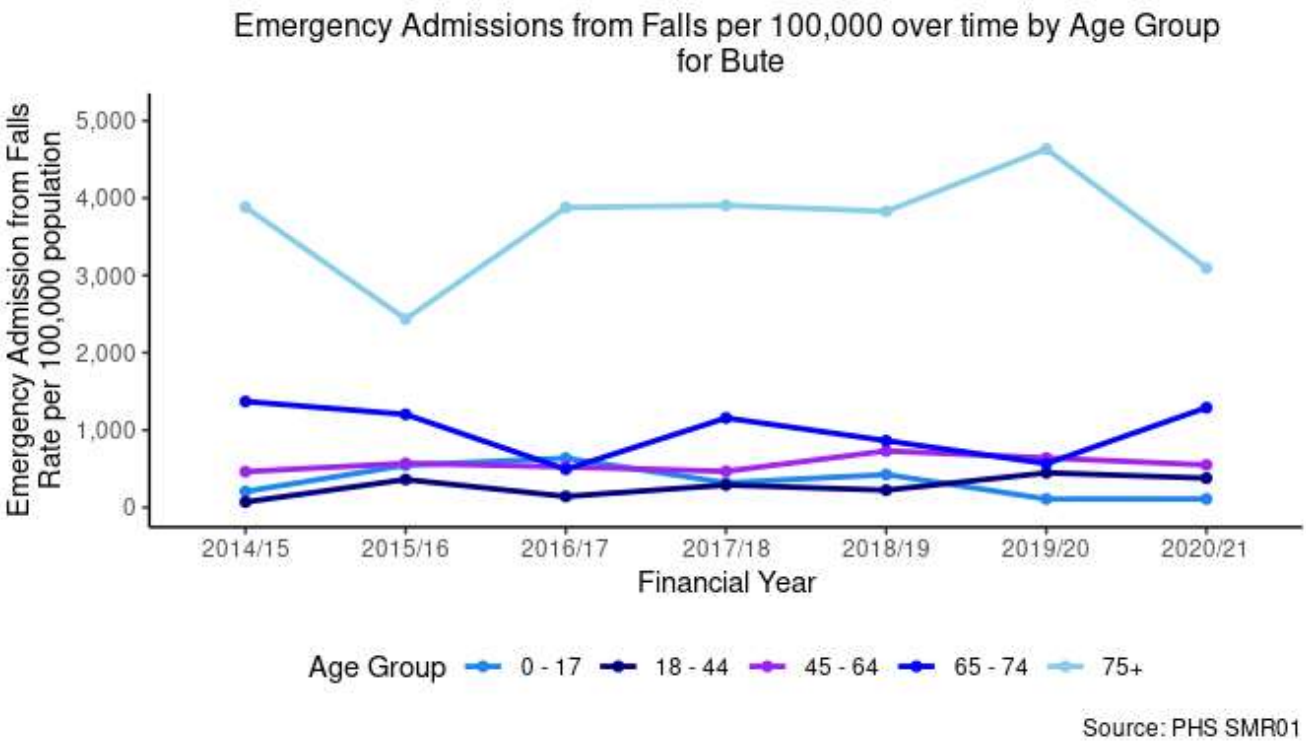
Figure 32: Delayed discharge bed days by geographical area



Source: PHS Delayed Discharges

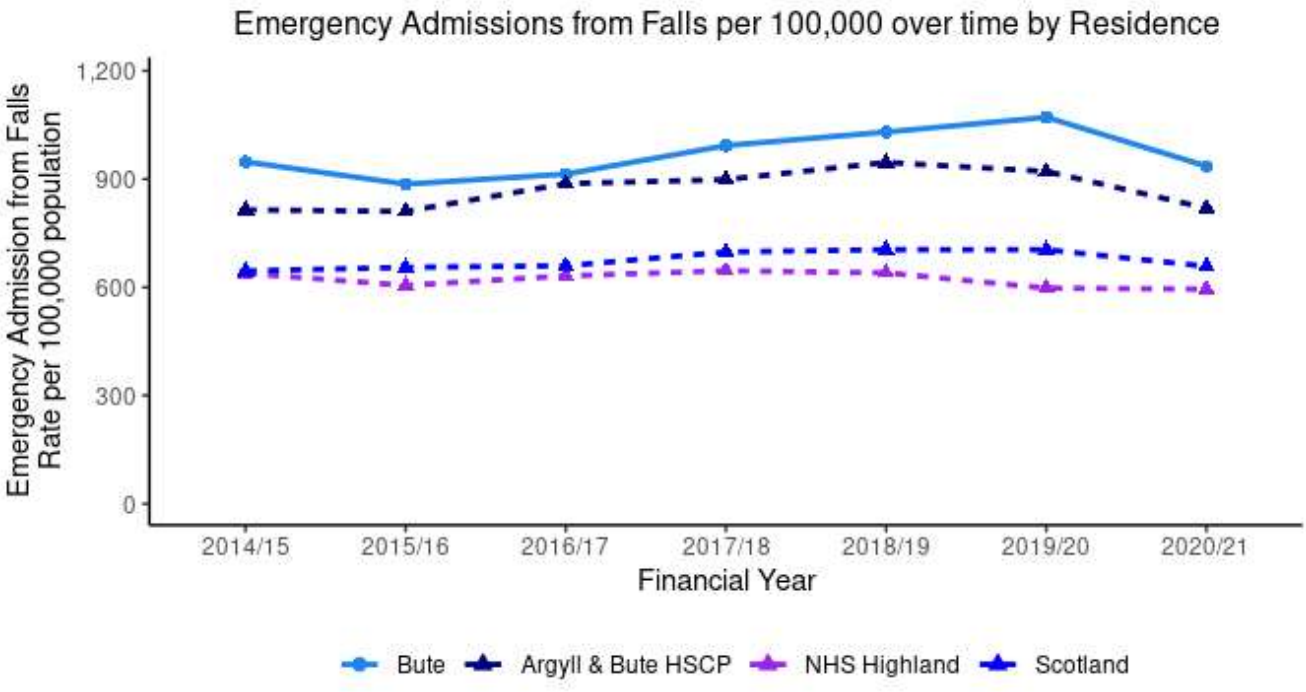
Emergency Admissions from a Fall

Figure 33: Falls by age group



Source: PHS SMR01

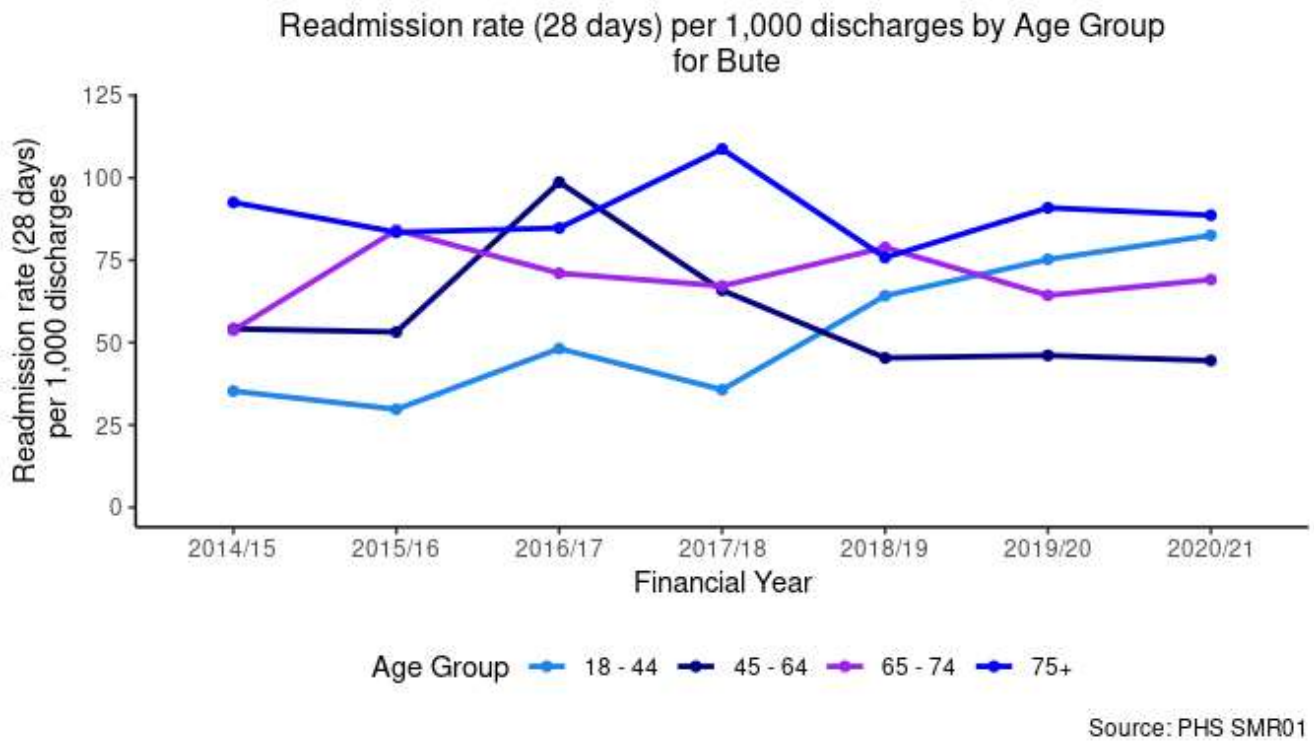
Figure 34: Falls by geographical area



Source: PHS SMR01

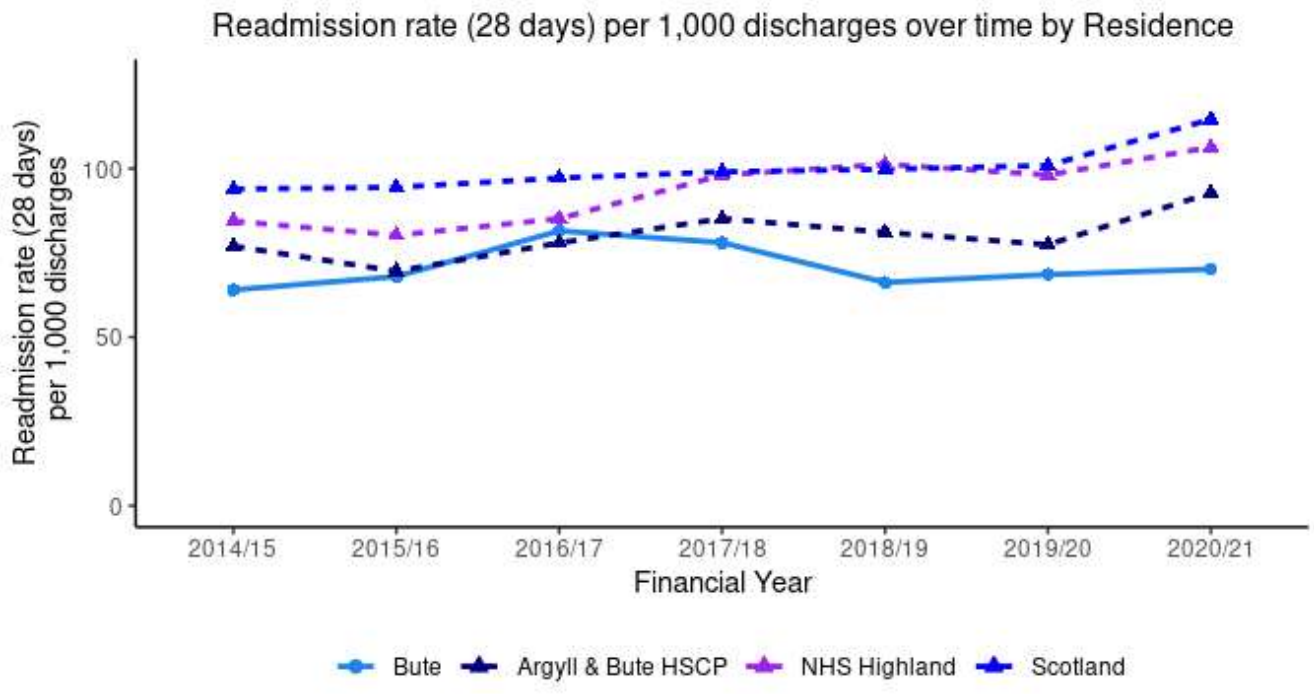
Emergency Readmissions (28 days)

Figure 35: Emergency readmissions by age group



Source: PHS SMR01

Figure 36: Emergency readmissions by geographical area

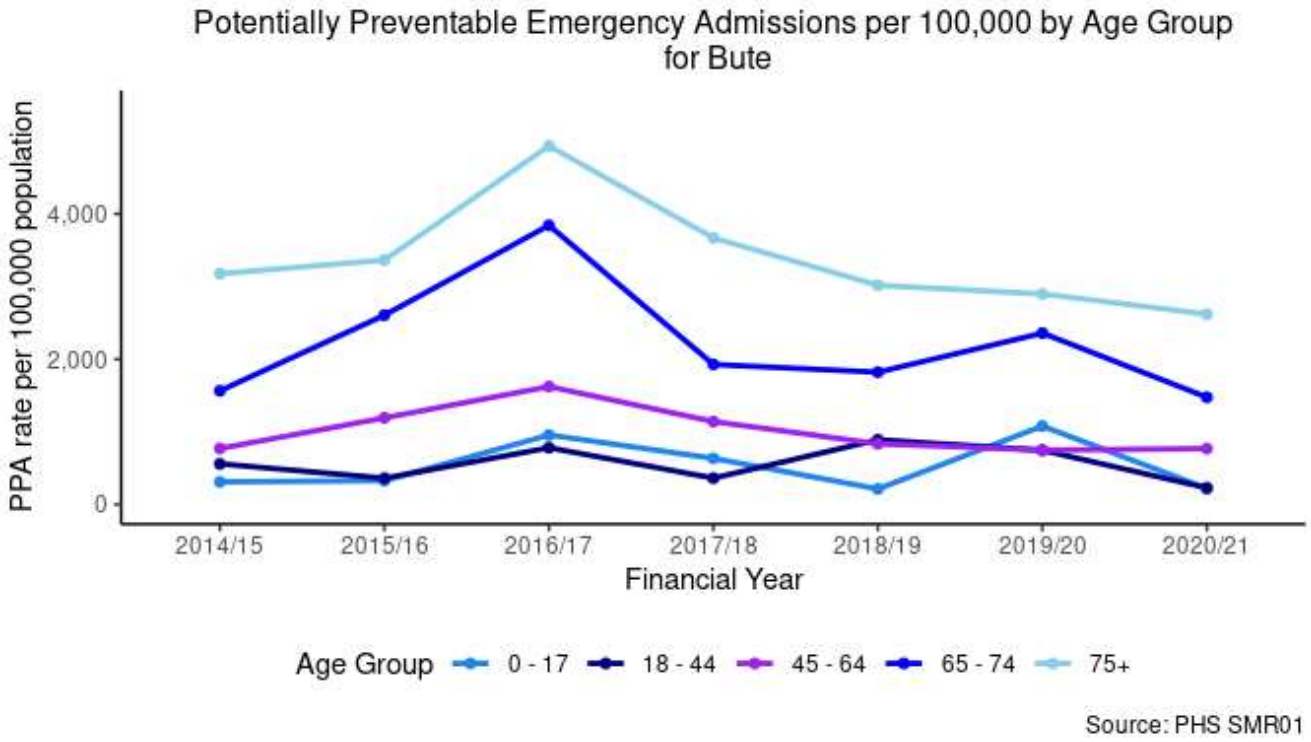


Source: PHS SMR01

Potentially Preventable Admissions (PPAs)

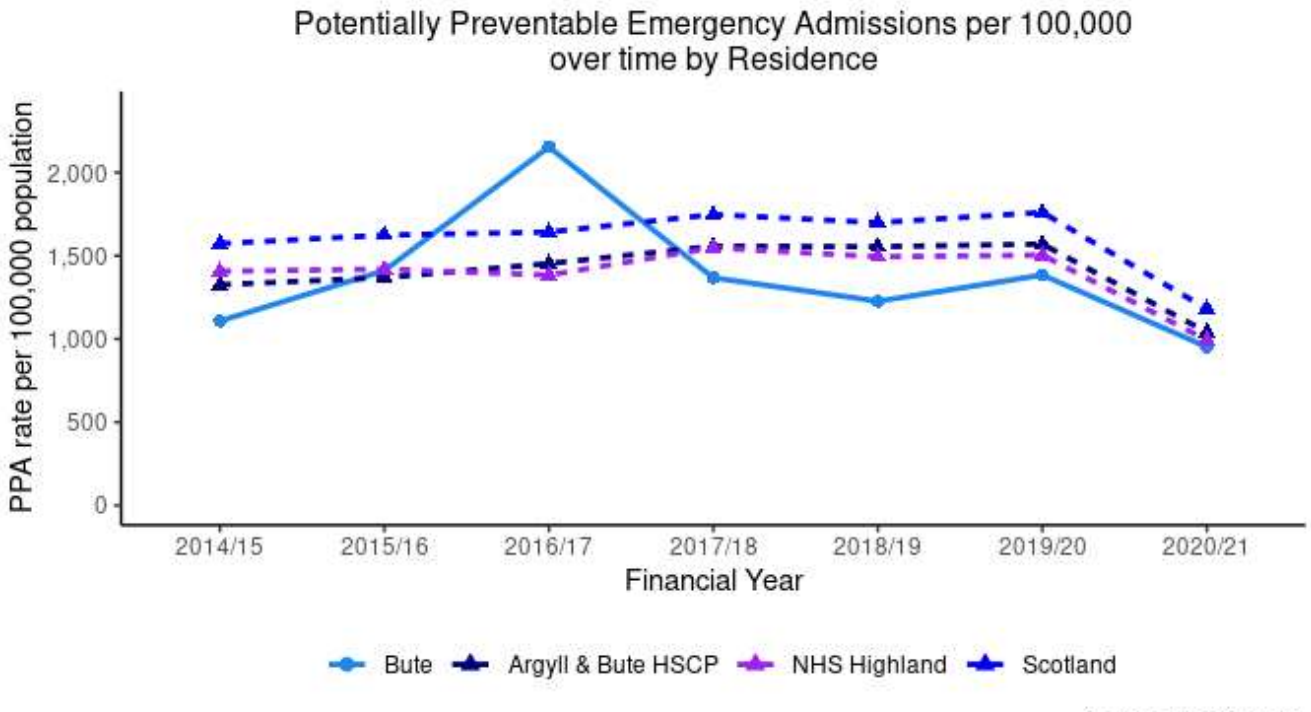
Information on which conditions are counted as PPAs is available in Appendix 3 in the accompanying summary document.

Figure 37: PPAs by age group



Source: PHS SMR01

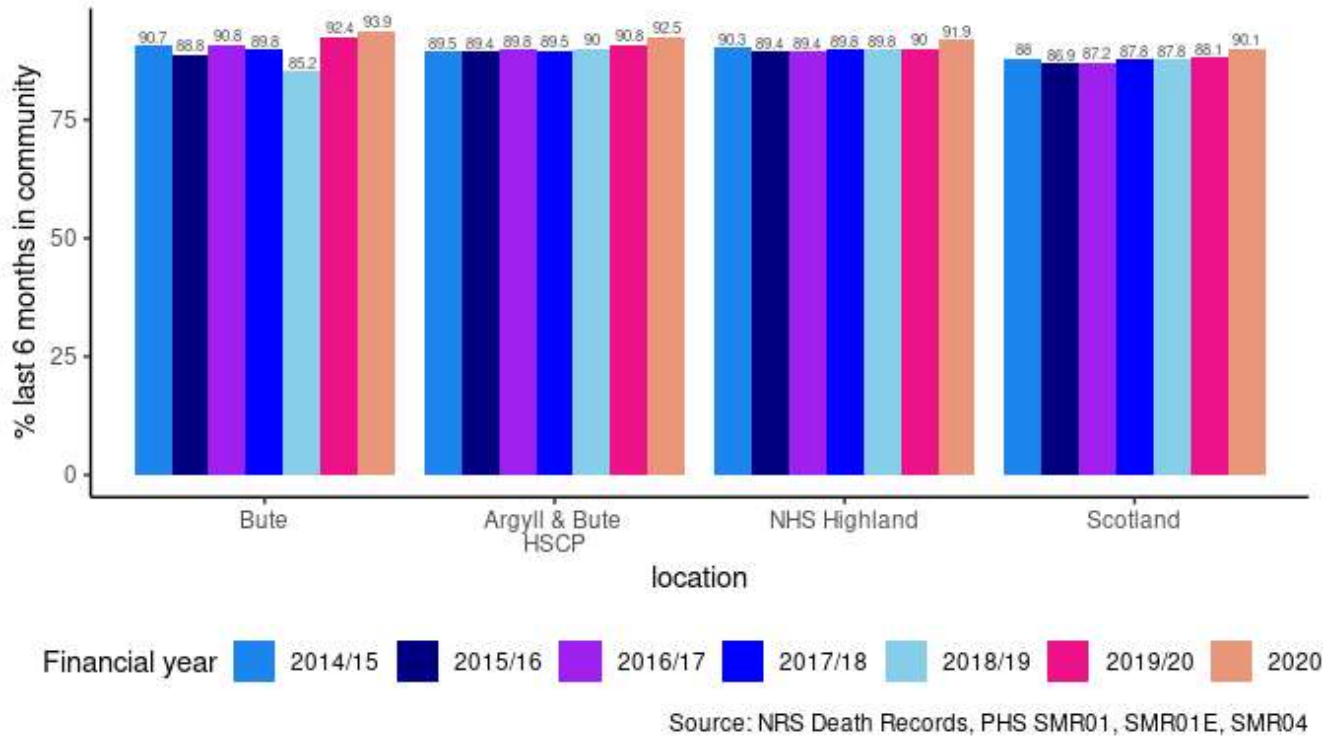
Figure 38: PPAs by geographical area



Source: PHS SMR01

% Last 6 months in a Community Setting

Figure 39: Last 6 months in a community setting by geographical area



Source: NRS Death Records, PHS SMR01, SMR01E, SMR04

Footnotes

1. Population projections are not currently provided by NRS at the locality level. To explore how the population in Bute is expected to change in the future, the percent changes in population projection to 2025 for Argyll and Bute by age group and gender were calculated from the NRS Local Authority Population Projections. These percent changes were then applied to the Bute 2018 mid-year population estimates (also split by age group and gender) to obtain population projection estimates for Bute, based on the projections for the HSCP and the current population structure of the locality.
2. Care Home Data included in the Services Map and Table was sourced from the Care Inspectorate. GP Practice data from October 2021, and Hospital and A&E data was sourced from Public Health Scotland Open Data. Only services that are within the physical boundary of the HSCP or Locality are included in the map and table, so there may be services outside Argyll and Bute which people may use but are not shown.
3. The data used in General Health and Behavioural Factors sections (except for long-term conditions) of this locality profile are taken from ScotPHO. There may be more recent data available for the indicators elsewhere.
4. Data taken from ScotPHO is often reported using the European Age-Sex Standardised Rate per 100,000. This allows for comparisons across different areas to be made. For more information on how these rates are calculated, please refer to www.isdscotland.org/Products-and-Services/GPD-Support/Population/Standard-Populations/
5. Physical long-term conditions data comes from the Source Linkage Files, and the conditions are identified using ICD-9 and ICD-10 codes in the diagnosis fields. Please note that the Source Linkage Files data only contains information on people who have had contact with the NHS through either inpatient admissions, outpatient attendances, daycase attendances, A&E attendances or through prescribed items, the data does not show all service users in Scotland who have been diagnosed with an LTC as not all of these individuals will have used these services. Also note that LTC rates are based on an adjusted population indicator in the Source Linkage Files so that population sizes are closer to the official estimates.
6. The 2020 COVID-19 pandemic will have had an effect on the most recent data available. A dashboard has been created by PHS which show the wider impacts of COVID-19 over many areas. You can access this here: https://scotland.shinyapps.io/phs-covid-wider-impact/

Locality Profile

Cowal Locality

October 2021

Table of Contents

Notes for this profile:

- All years shown are calendar years unless otherwise specified.
- Upper and lower 95% confidence intervals are shown throughout this document where available. In charts, these are displayed as shaded areas either side of trend lines, or as black error bars in bar charts. Confidence intervals show the range of possible values and a certainty that the true value falls within them.
- Definitions for the indicators shown are available in Appendix 1 in the accompanying summary document.
- Any zero figures for some indicators will indicate either suppression of small data or a complete lack of data available for this locality
- Data should be interpreted with caution, particularly for areas with relatively small population sizes where indicator data is expected, by chance alone, to have higher variation than in areas of larger population size. Note that differences between areas can relate to multiple factors including, for example, underlying rates of illness, rates of diagnosis and local differences in practice e.g. in data recording.

Demographics

Summary:

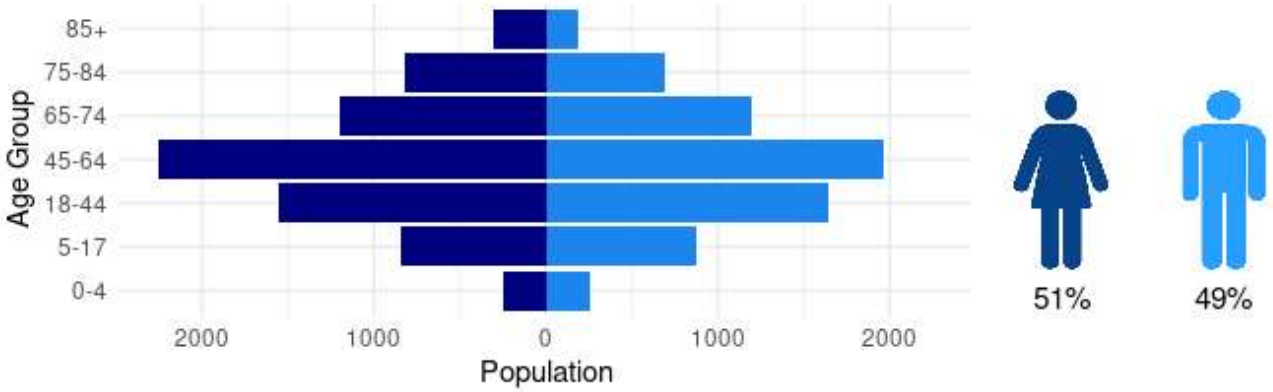
For the most recent time periods available, Cowal Locality had:

- A total population of **14,014** people, where **49%** were male, and **31%** were aged over 65.
- **0%** of people lived in the least deprived SIMD quintile, and **13%** lived in the most deprived quintile.

Population

In 2020, the total population of Cowal locality was 14,014. The graph below shows the population distribution of the locality.

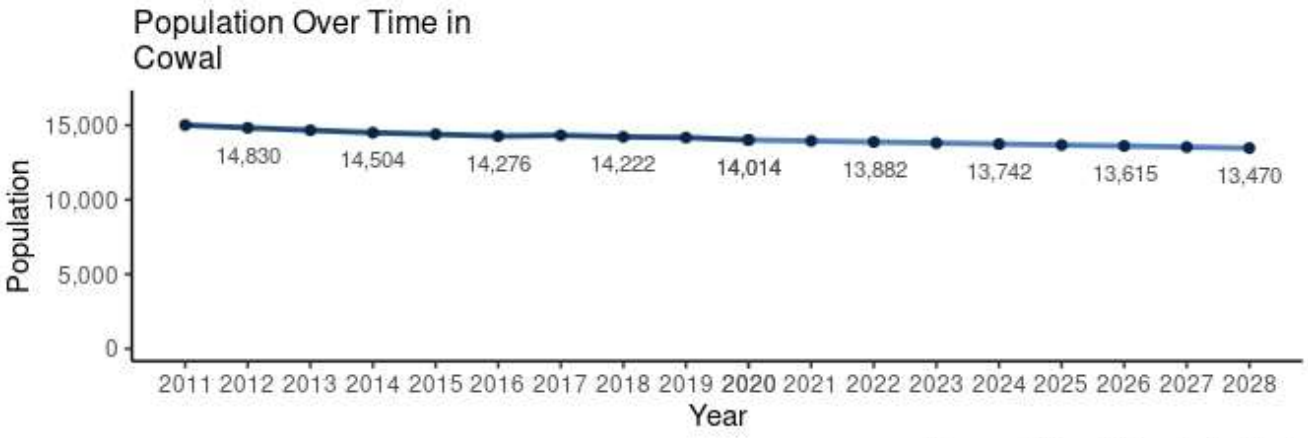
Figure 1: Population breakdown in Cowal.



Source: National Records Scotland

Figure 2 shows the historical population of Cowal, along with the NRS population projections. The population has been falling. The population in Cowal is estimated to decrease by 2.4% from 2020 to 2025 *Please see the footnotes for more information on how the population projections were calculated*[1].

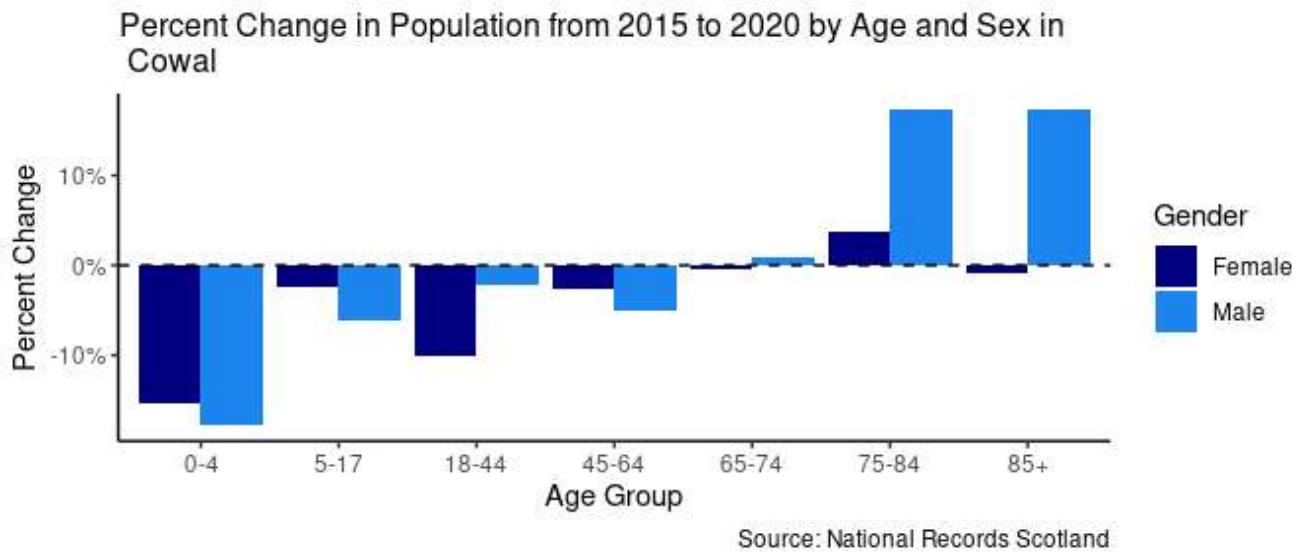
Figure 2: Population time trend and projection.



Source: National Records Scotland

Figure 3 shows how population structure has changed between 2015 and 2020.

Figure 3: Change in population structure over the last five years.



Deprivation

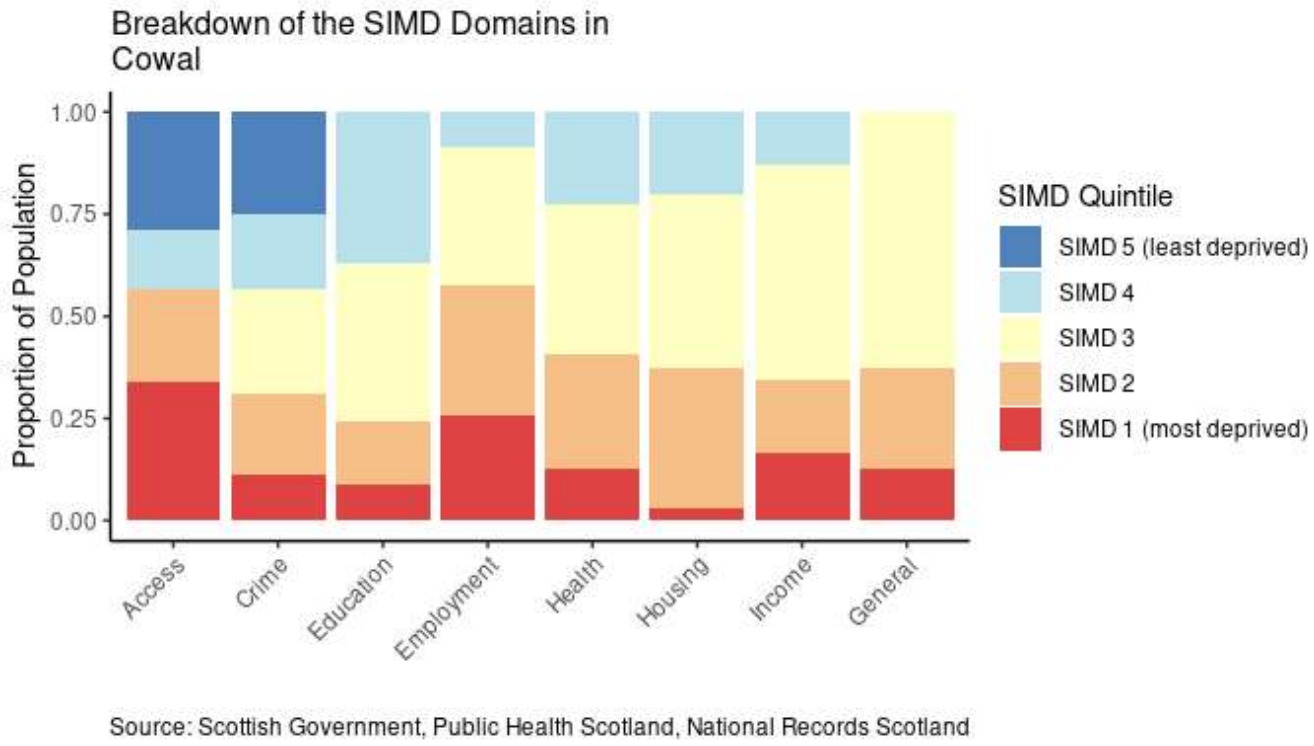
The following section explores the deprivation structure of Cowal through the Scottish Index of Multiple Deprivation (SIMD). The SIMD ranks all datazones in Scotland by a number of factors; Access, Crime, Education, Employment, Health, Housing and Income. Based on these ranks, each datazone is then given an overall deprivation rank, which is used to split datazones into Deprivation Quintiles (Quintile 1 being the most deprived, and Quintile 5 the least). The most recent SIMD ranking was carried out in 2020. This section mainly focuses on the SIMD 2020 classifications, however the 2016 classifications are used to assess how deprivation has changed in Cowal when compared to the rest of Scotland.

Of the 2020 population in Cowal, **13%** live in the most deprived SIMD Quintile, and **0%** live in the least deprived SIMD Quintile. The following table details the percent of the population living in the 2016 SIMD Quintiles, the percent living in the 2020 SIMD Quintiles, and their difference for comparison.

Table 1: Percentage population living in the 2016 and 2020 SIMD Datazone Quintiles

Quintile	Percent of Pop (2016)	Percent of Pop (2020)	Difference
SIMD 1	12.7%	12.8%	0.1%
SIMD 2	31.6%	24.3%	-7.3%
SIMD 3	55.7%	62.8%	7.2%
SIMD 4	0.0%	0.0%	0.0%
SIMD 5	0.0%	0.0%	0.0%

Figure 4: Proportion of the population that reside in each 2020 SIMD quintile by domain.



Source: Scottish Government, Public Health Scotland, National Records Scotland

Households

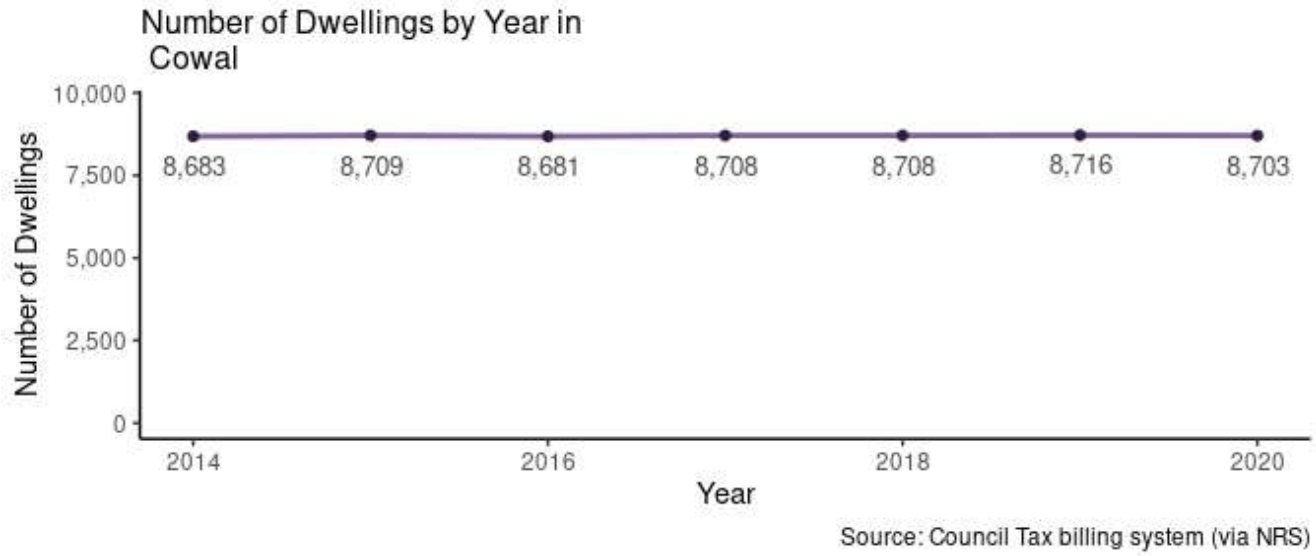
Summary:

For the most recent time periods available, Cowal Locality had:

- **8,703** dwellings, of which: **87%** were occupied and **8.6%** were second homes.
- **34%** of dwellers received a single occupant council tax discount, and **1.7%** were exempt from council tax entirely.
- **63%** of houses were within council tax bands A to C, and **8.2%** were in bands F to H.

The graph below shows the number of dwellings in Cowal from 2014 to 2020.

Figure 5: Number of dwellings time trend.



Of the total number of dwellings in 2020, 34% (2,978 households) were occupied by an individual receiving a single occupant council tax discount. Furthermore, 1.7% (146 households) were occupied and exempt from council tax.

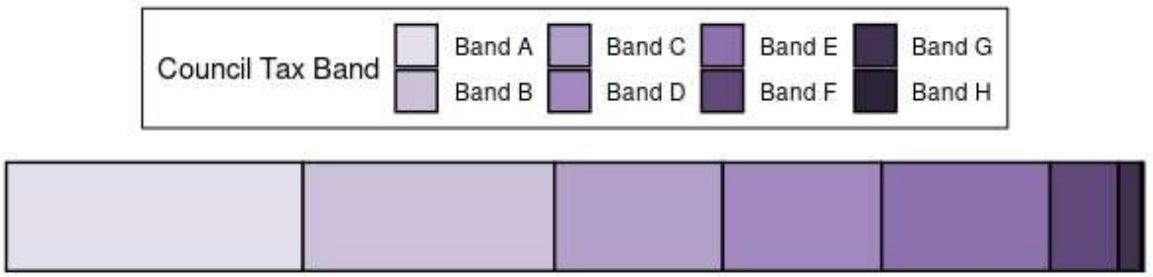
There were 751 dwellings classed as a second home in 2020, these dwellings made up 8.6% of the households in Cowal.

Table 2: Breakdown of dwelling types by year for Cowal locality.

Year	Total Dwellings	Occupied Dwellings	Vacant Dwellings	Single Occupant Tax Discount	Council Tax Exempt Dwellings	Second Homes
2014	8,683	7,357	484	2,985	119	841
2015	8,709	7,403	447	2,881	121	860
2016	8,681	7,366	463	2,908	122	852
2017	8,708	7,484	409	2,901	113	813
2018	8,708	7,517	397	2,915	117	794
2019	8,716	7,555	396	2,931	132	765
2020	8,703	7,537	415	2,978	146	751

The proportion of households within each council tax band are displayed in the chart below, figures are shown in Table 3.

Figure 6: Breakdown of households by council tax band for Cowal in 2020.



Source: Scottish Assessors' Association (via NRS)

Table 3: Percentage of households by council tax band for Cowal in 2020.

Tax Band	A	B	C	D	E	F	G	H
Percent of households	26%	22%	15%	14%	15%	6%	2%	0.23%

General Health

Summary:

For the most recent time periods available[3], Cowal Locality had:

- **An average life expectancy of 77.1 years for males and 80.1 years for females.**
- **A death rate for ages 15 to 44 of 152 deaths per 100,000 age-sex standardised population[4]**
- **27%** of the locality's population with at least one long-term physical health condition.
- A cancer registration rate of **610** registrations per 100,000 age-sex standardised population[4]
- **23.12%** of the population being prescribed medication for anxiety, depression, or psychosis.

Life Expectancy

In the latest time period available from 2016-2020 (5 year aggregate), the average life expectancy in Cowal locality was 77.1 years old for men, and 80.1 years old for women. A time trend since 2013-2017 can be seen in figure 8.

Figure 8: Average life expectancy in men and women over time.

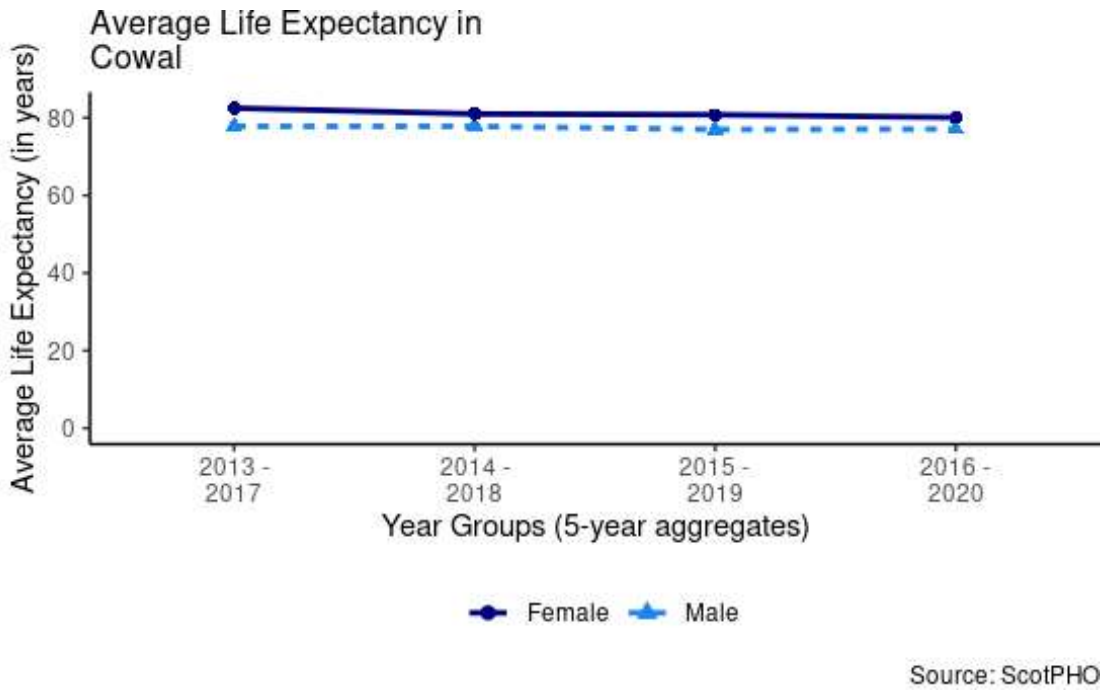


Table 5 provides the average life expectancy for men and women in different areas for the latest time period available. Please note that these are 5 year aggregates for the locality from 2016-2020, but 3 year aggregates from 2018-2020 at partnership, Health Board, and Scotland level.

Table 5: Average life expectancy in years for the latest time periods (2016-2020 aggregated years for the locality; 2018-2020 aggregated years for other areas).

	Locality	Partnership	Health Board	Scotland
	80.1	81.6	81.8	81
	77.1	78	77.6	76.8

Where Locality = Cowal, Partnership = Argyll and Bute HSCP, Health Board = NHS Highland.

Deaths, aged 15-44

The following chart shows a trend of death rates among 15-44 year olds per 100,000 age-sex standardised population[4] by area (i.e. Early mortality rate per 100,000). In the most recent aggregate time period available (from 2018-2020), the mortality rate in Cowal locality was **152** deaths per 100,000 population. Figure 10 then provides comparisons of deaths for all localities in Argyll and Bute HSCP, for the two latest time aggregates available.

Figure 9: Deaths aged 15-44 years by geographical area and over time.

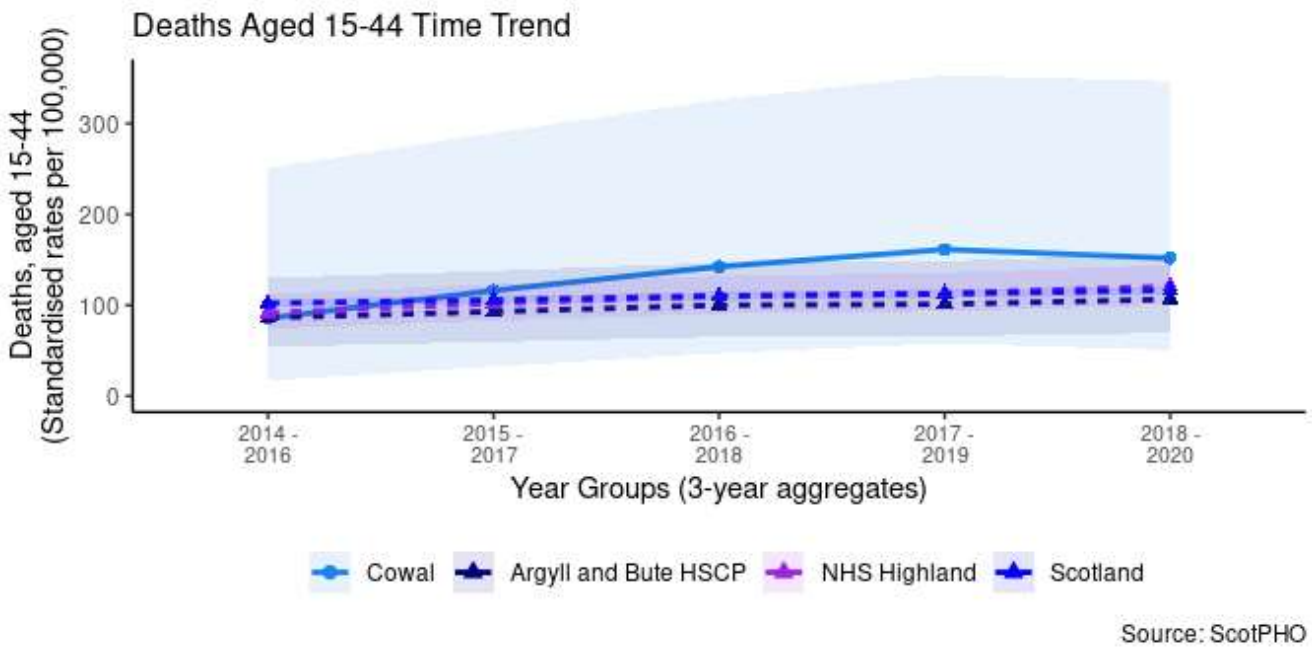
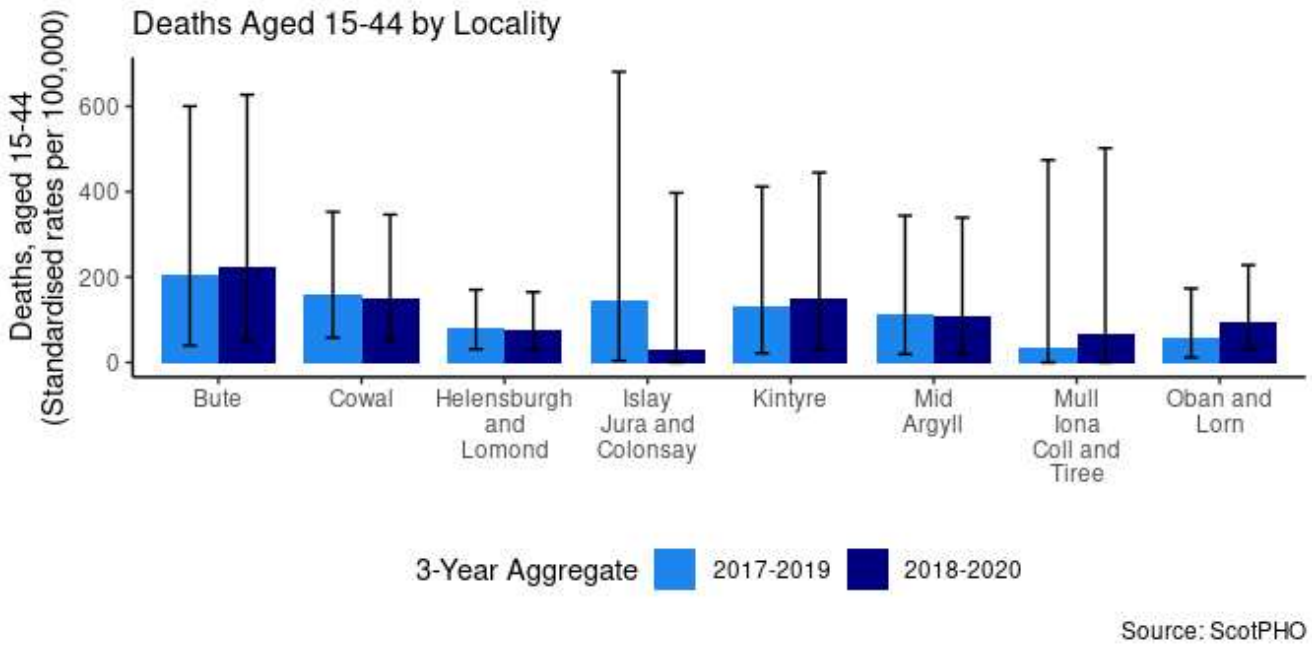
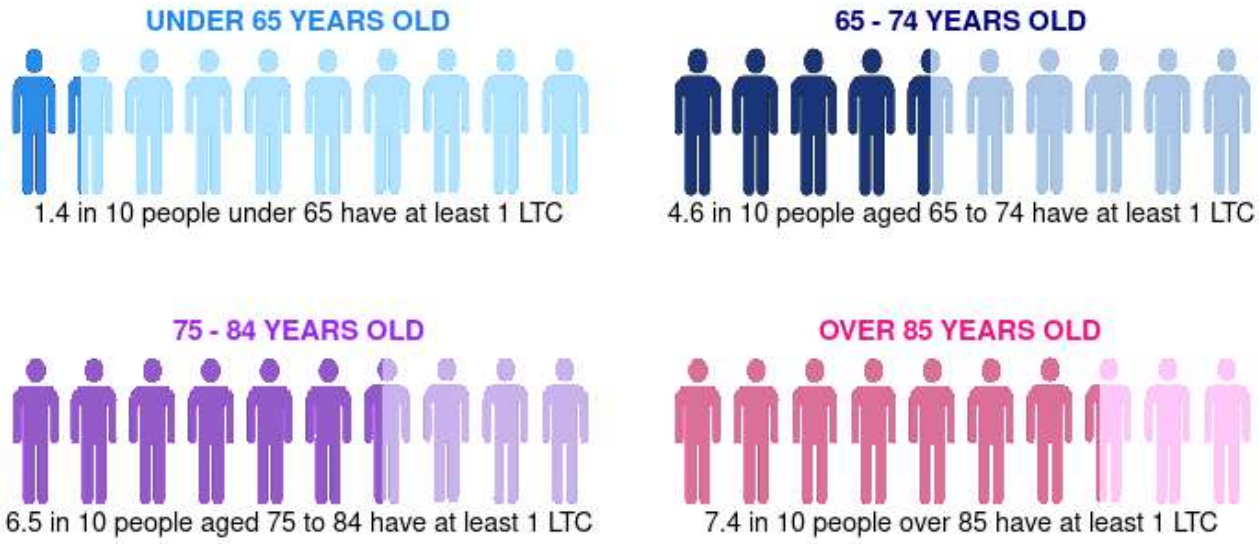


Figure 10: Deaths at ages 15-44 in Argyll and Bute HSCP localities.



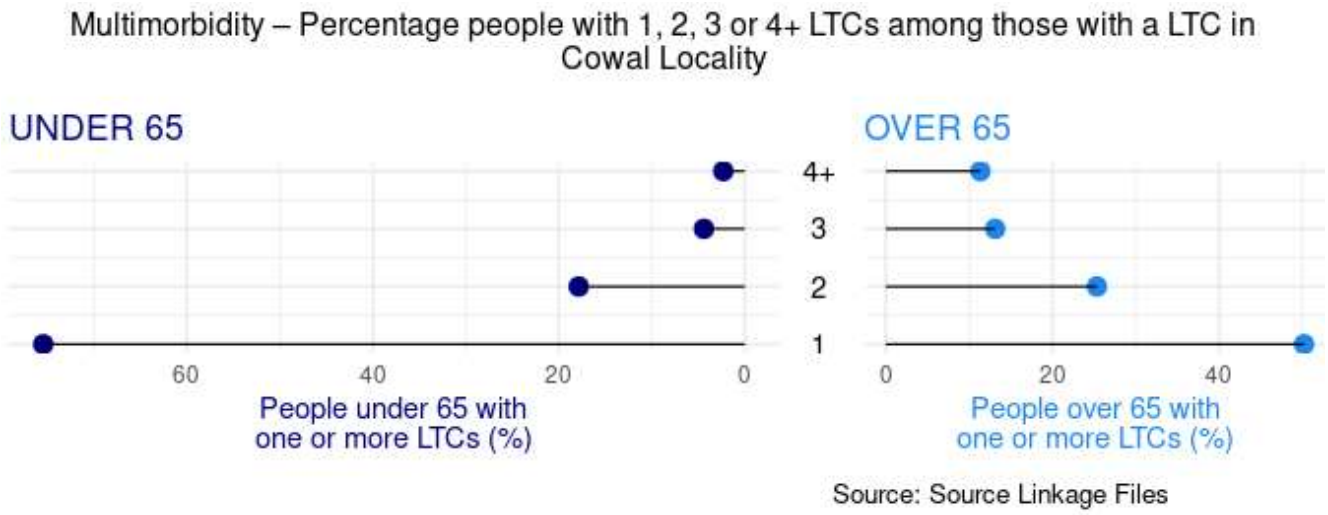
Long-Term Physical Health Conditions and Multimorbidity

In the financial year 2020/21, in Cowal Locality, **27%** of the total population had at least one physical long-term condition (LTC). These include: cardiovascular, neurodegenerative, and respiratory conditions, as well as other organ conditions (namely liver disease and renal failure), arthritis, cancer, diabetes, and epilepsy. *Please see footnotes for information and caveats on identifying LTCs.*[5]



The co-occurrence of two or more conditions, known as multimorbidity, is broken down in figure 11, distinguishing between age groups. Note that this chart *excludes* the population in the locality who do not have any physical long-term conditions. Figure 13 therefore shows that among the people who have a LTC, **25**% of those under the age of 65 have more than one, compared to **50**% of those aged over 65.

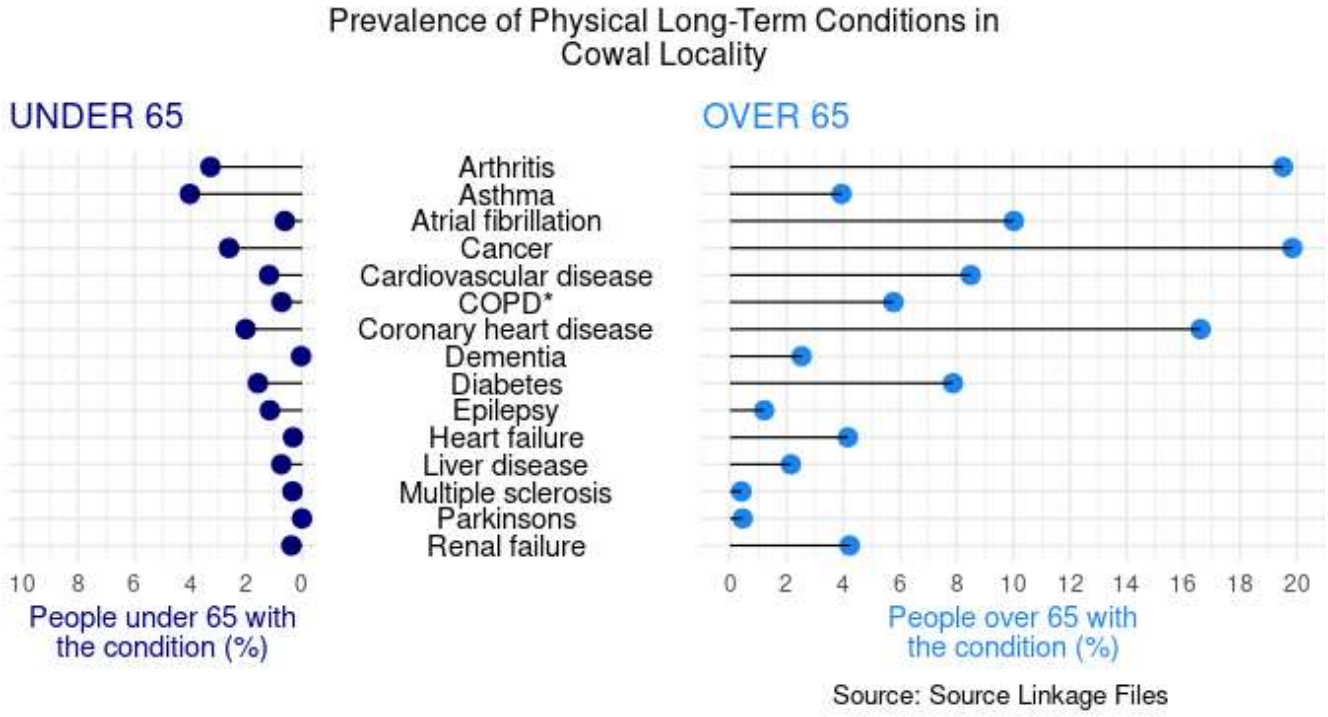
Figure 11: Multimorbidity of physical long-term conditions by age group in 2020/21.



Most common physical Long-Term Conditions (LTCs)

Below is a breakdown of the physical LTCs, for the financial year 2020/21. Figure 12 shows the prevalence of different LTCs in each age group in Cowal locality, and Table 6 illustrates the top 5 physical LTCs across all ages at locality, partnership, and Scotland level.

Figure 12: Percentage people with each physical LTC, split by age group.



COPD: Chronic Obstructive Pulmonary Disease

Table 6: Prevalence of the five most common physical LTCs as a percentage of the population across geographical areas (where 1 = most prevalent).

Top 5 Physical Long-Term Conditions

	Cowal Locality	*Argyll and Bute HSCP*	*Scotland*
1	Arthritis 8.4%	Arthritis 6.9%	Arthritis 5.6%
2	Cancer 8%	Cancer 6.6%	Cancer 5.1%
3	Coronary heart disease 6.6%	Coronary heart disease 5.5%	Coronary heart disease 4.7%
4	Asthma 4%	Asthma 3.8%	Asthma 4.7%
5	Atrial fibrillation 3.6%	Diabetes 3.2%	Diabetes 3.2%

Cancer Registrations

For the period 2017-2019, there were 123 new cancer registrations per year on average (**610** registrations per 100,000 age-sex standardised population) in Cowal locality. This is a **2%** decrease in cancer registrations rate from the previous aggregate period 2016-2018. Figure 13 shows changes over time since 2014-2016, and Figure 14 compares the rates of localities in Argyll and Bute HSCP for the two latest available time periods.

Figure 13: Cancer registration rate over time and by geographical area.

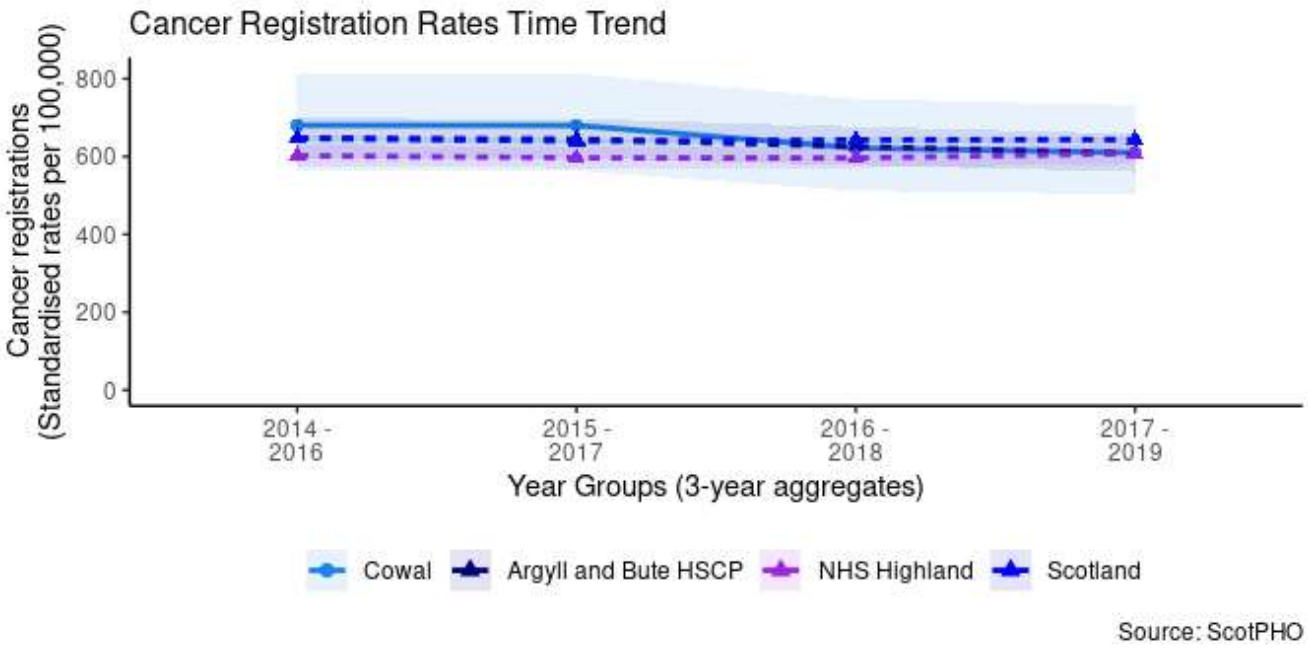
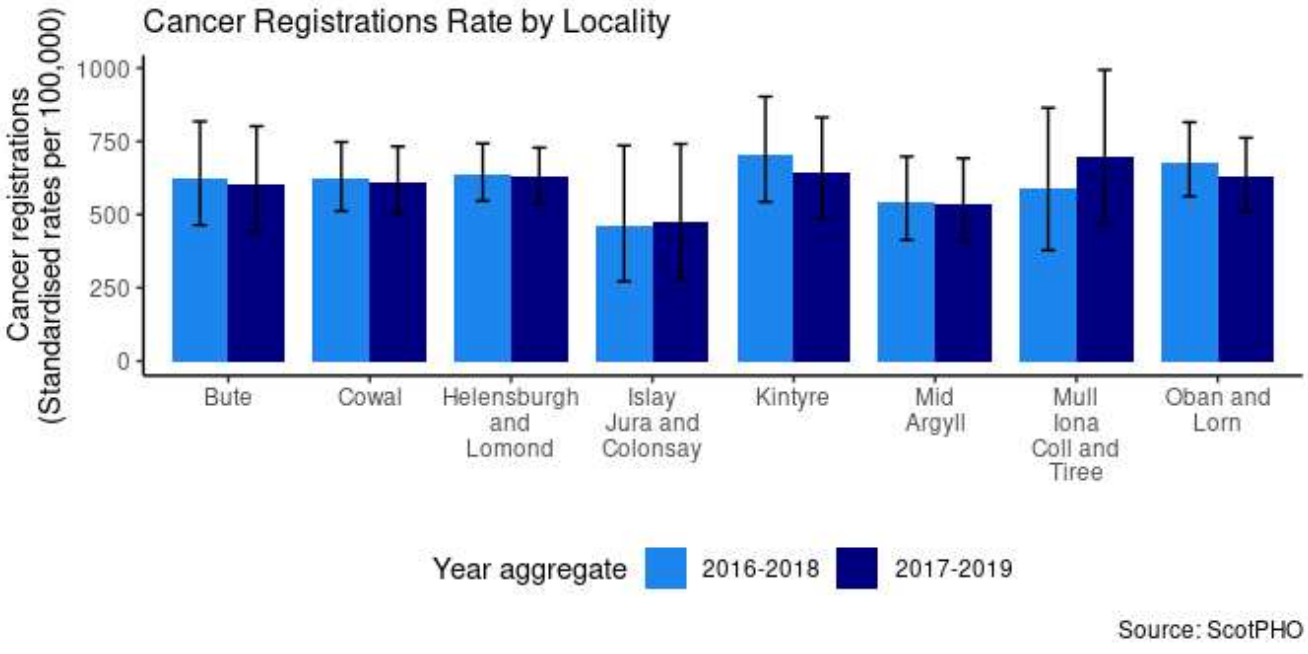


Figure 14: Cancer registration rates in Argyll and Bute HSCP localities.



Anxiety, Depression, and Psychosis Prescriptions

In the 2019/20 financial year, 23.12% of people were prescribed medication for anxiety, depression, or psychosis (ADP) in Cowal Locality. This is a 2.9% increase from the previous financial year. Differences over time and between areas may relate to multiple factors, only one of which is underlying disease. Note that data are based on main original licensed use for the prescriptions and some drugs included may be prescribed for other purposes.

Figure 15: Percentage population prescribed ADP medication in Argyll and Bute HSCP localities.

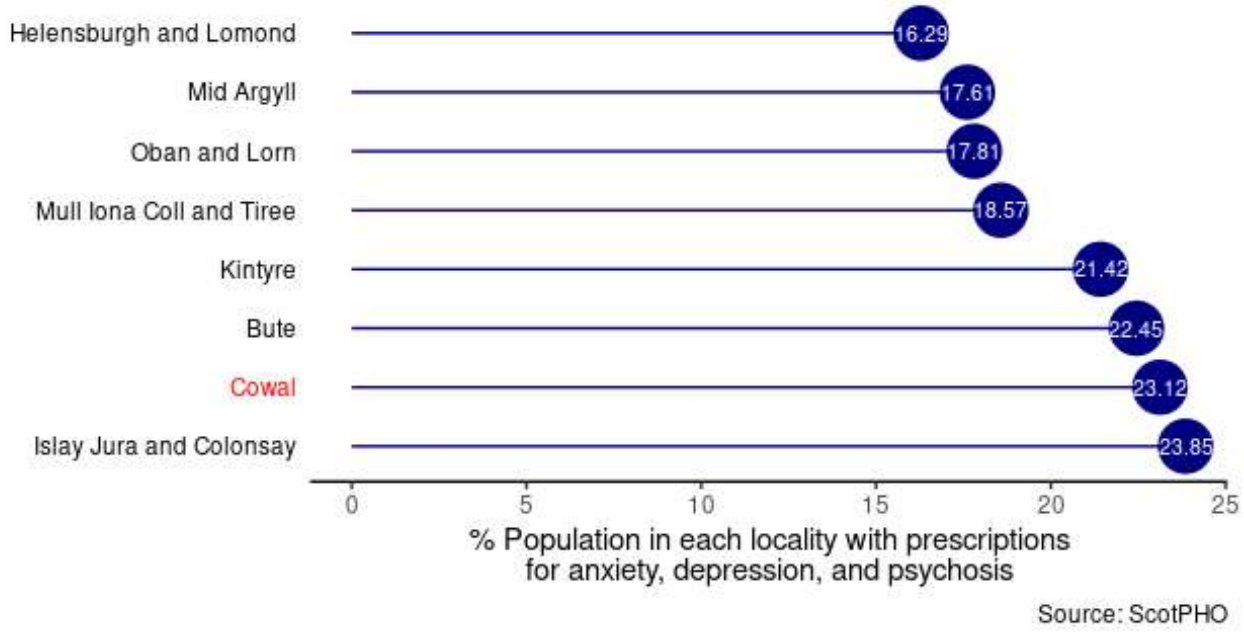
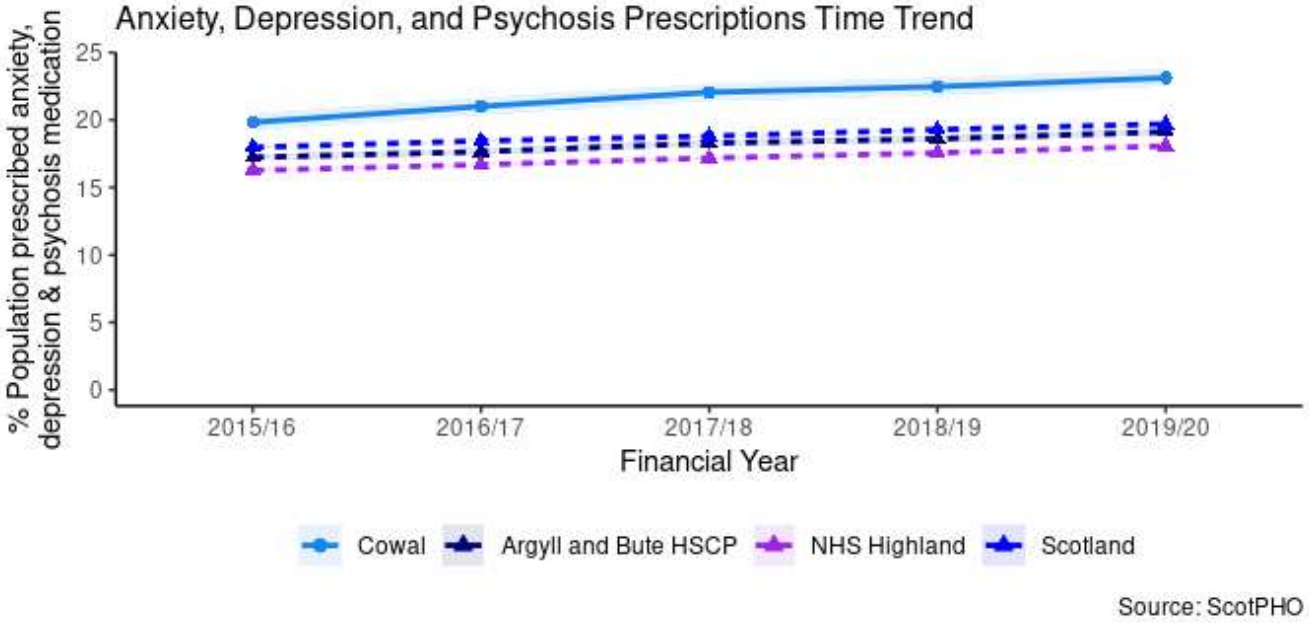


Figure 16: ADP prescriptions over time and by geographical area.



Behavioural Factors

Summary:

Mental and physical wellbeing has close ties with people's behaviours. Life circumstances including financial security, employment and location are interlinked with behavioural factors. This section provides data on drug-related hospital admissions, alcohol-related hospital admissions, alcohol-specific mortalities and bowel screening uptake, to give an overview of some behaviours known to be associated with health and wellbeing outcomes.

For the most recent time periods available[3], Cowal had:

- **188** drug-related hospital admissions per 100,000 age-sex standardised population[4]. This is a lower rate of admissions than for Scotland (221).
- **871** alcohol-related hospital admissions per 100,000 age-sex standardised population[4].
- **14** alcohol-specific mortalities per 100,000 age-sex standardised population[4].
- a **62%** uptake of bowel cancer screening for the eligible population.

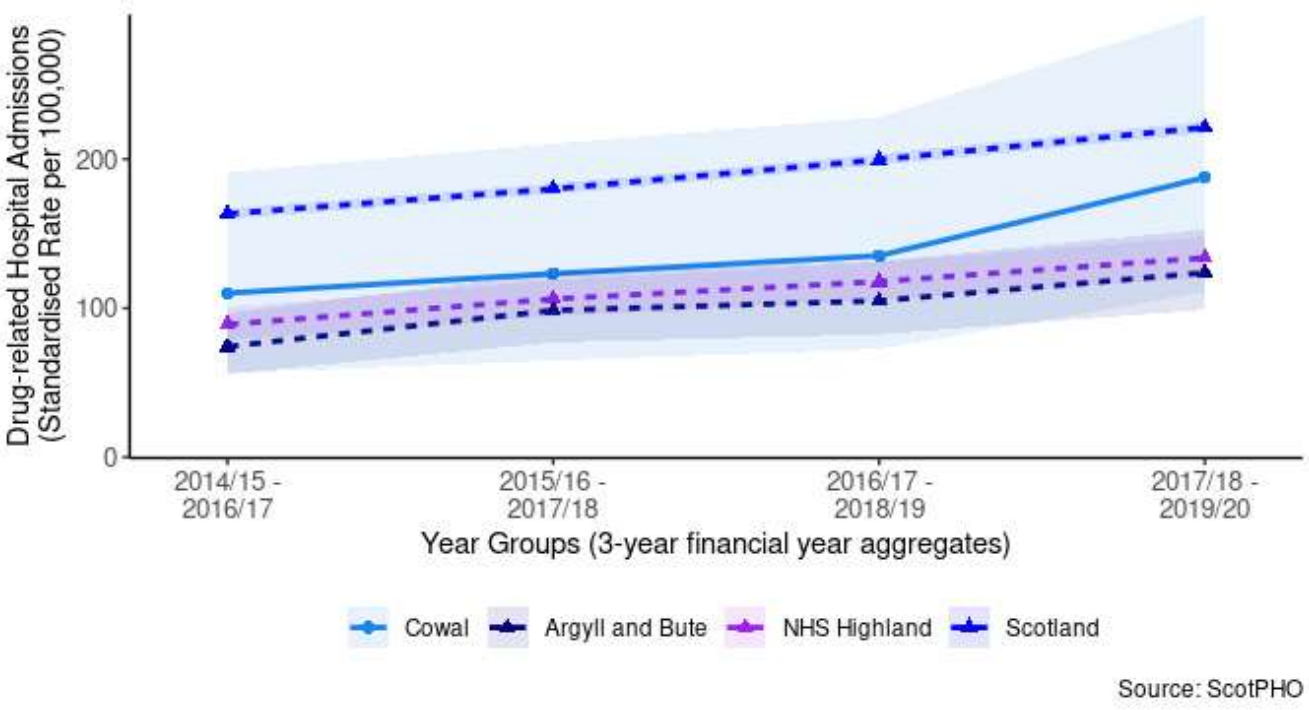
Drug-related Hospital Admissions

There were 188 drug-related hospital admissions per 100,000 age-sex standardised population[4] in Cowal locality for the most recent time period available (3 year financial year aggregate for 2017/18 - 2019/20).

This is a 71% increase since 2014/15 - 2016/17 (3 financial year aggregates).

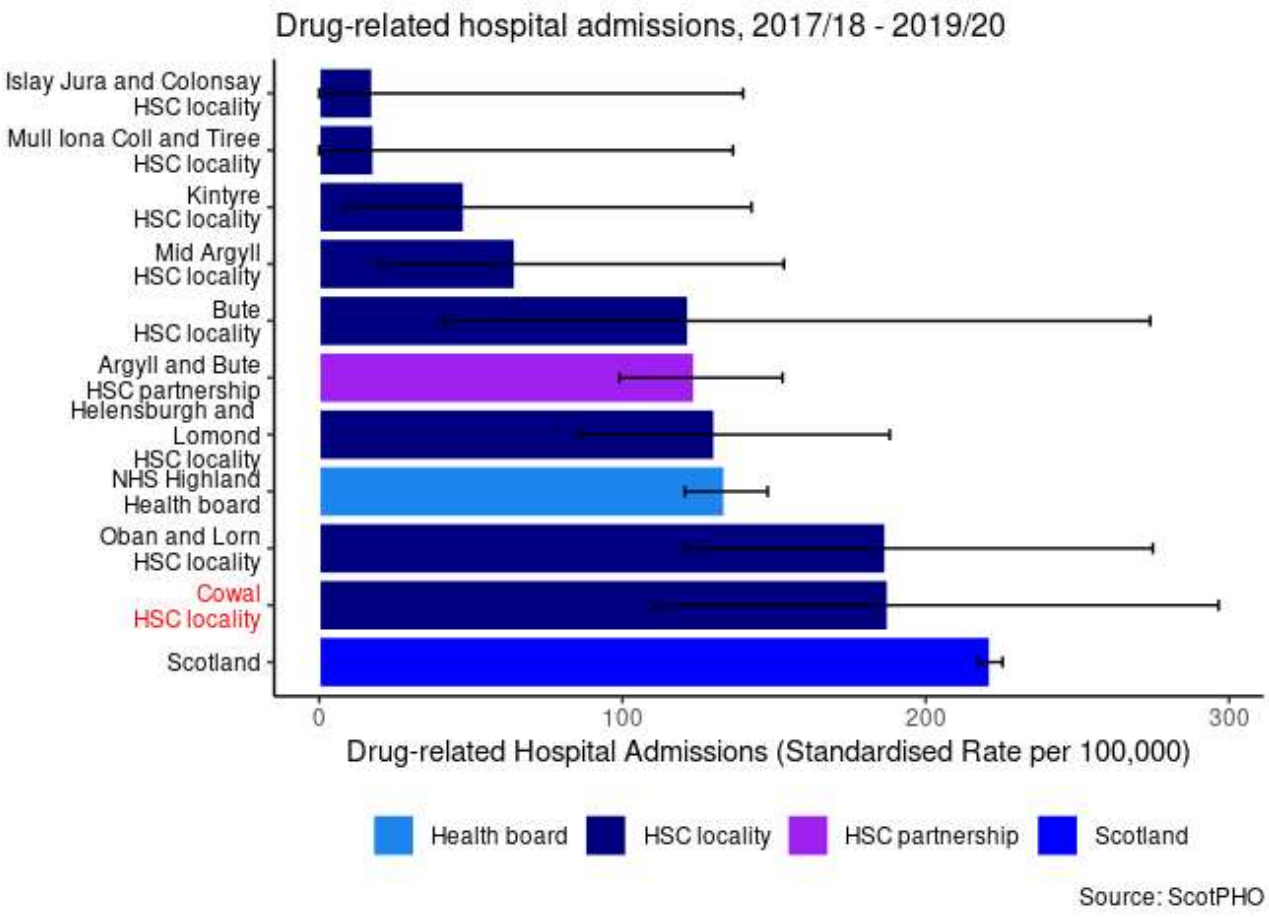
A trend of the change in drug-related hospital admissions for Cowal locality compared with Scotland, Argyll and Bute HSCP and NHS Highland is shown in the chart below from 2014/15 - 2016/17 onwards.

Figure 17: Trend of Drug-related Hospital Admission Rates by geographical area.



A comparison of areas at the most recent time period (2017/18 - 2019/20 aggregated financial years) is available below. This shows Cowal locality has a higher rate of admissions (188) than Argyll and Bute Partnership (124), and a lower rate of admissions than Scotland (221) overall.

Figure 18: Comparison of Drug-related Hospital Admission Rates for the period 2017/18 - 2019/20.

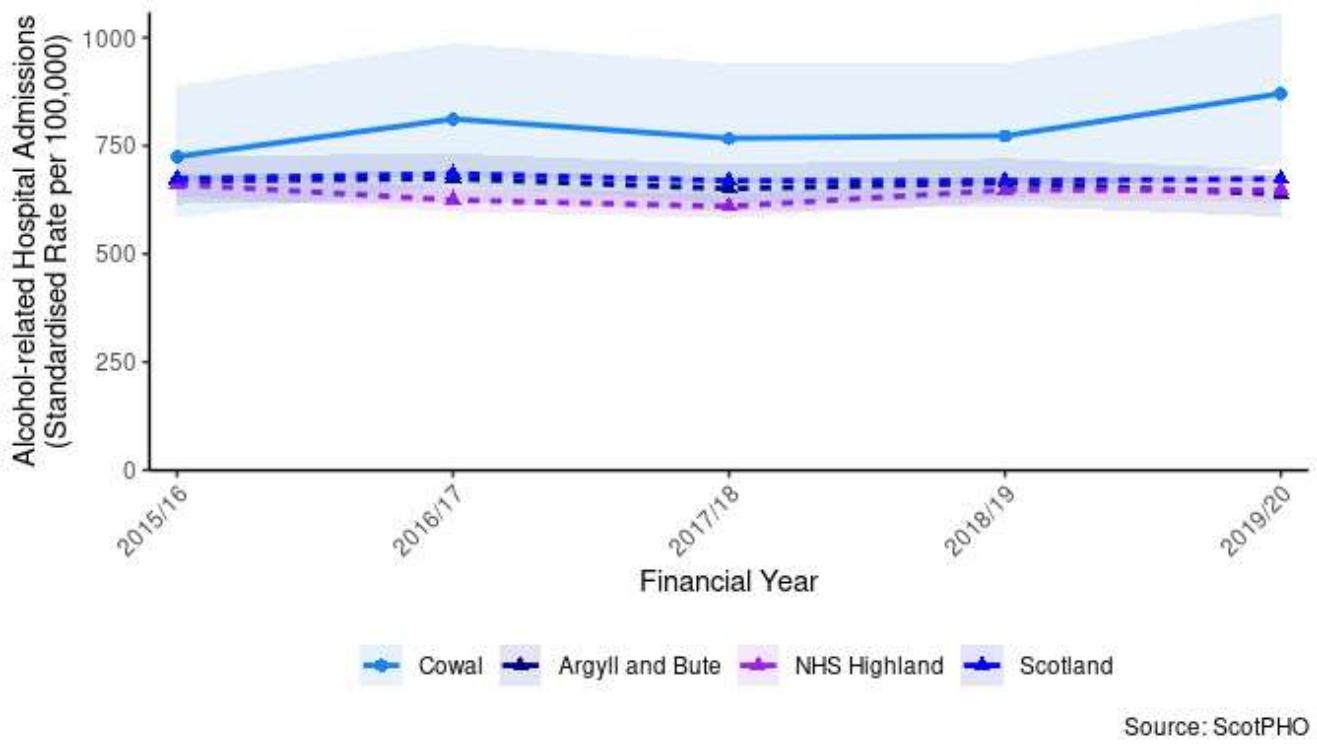


Alcohol-related Hospital Admissions

The 2019/20 alcohol-related admissions rate is 871 per 100,000 age-sex standardised population[4], which is a 20% increase overall since 2015/16.

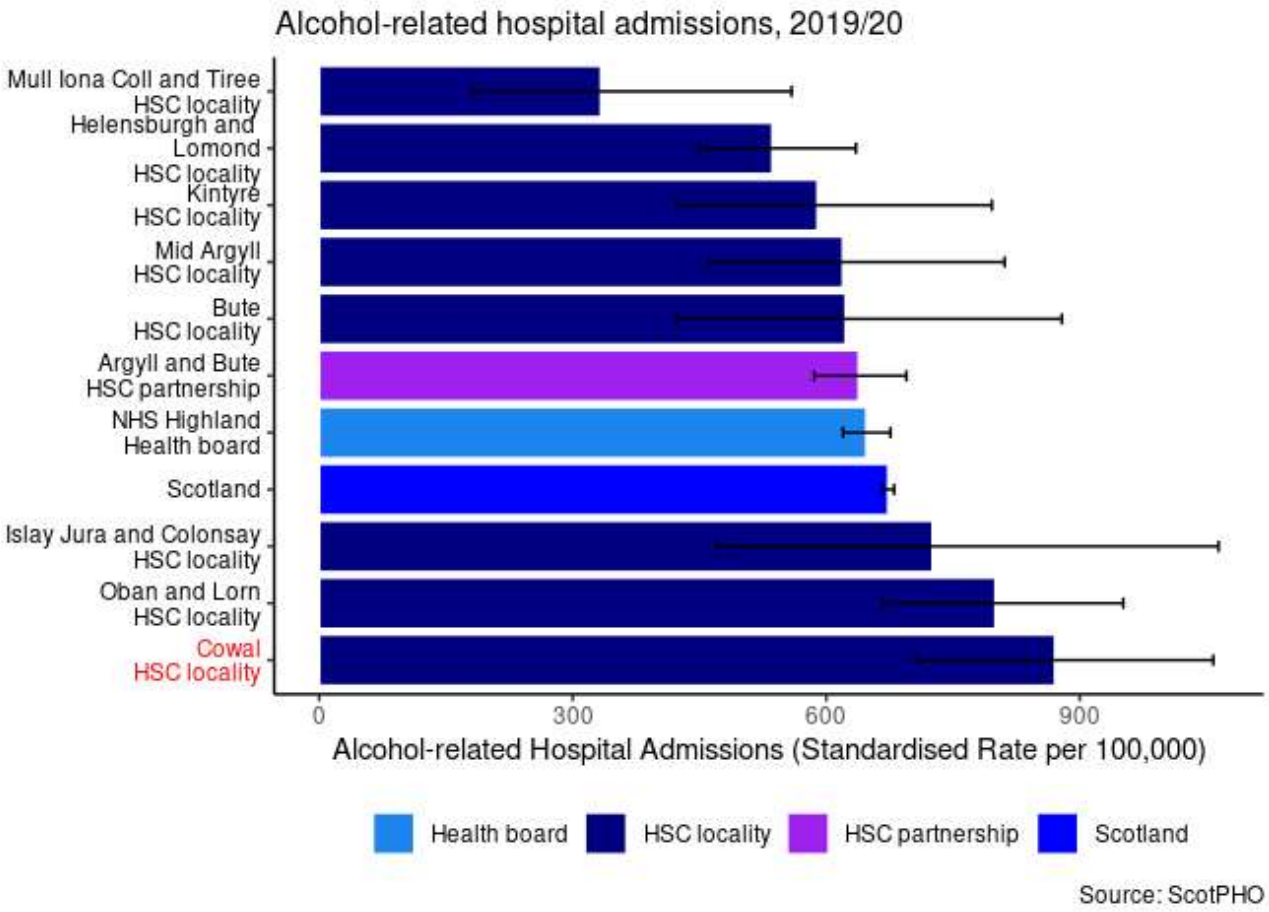
The chart below shows a trend of alcohol-related hospital admissions for Cowal locality compared with Scotland, Argyll and Bute Partnership and NHS Highland from financial year 2015/16 to 2019/20.

Figure 19: Trend of Alcohol-related Hospital Admission Rates by geographical area.



Comparison across different areas for 2019/20 is shown in Figure 20. This shows that Cowal locality had a higher alcohol-related hospital admissions rate (871) compared to Scotland (673).

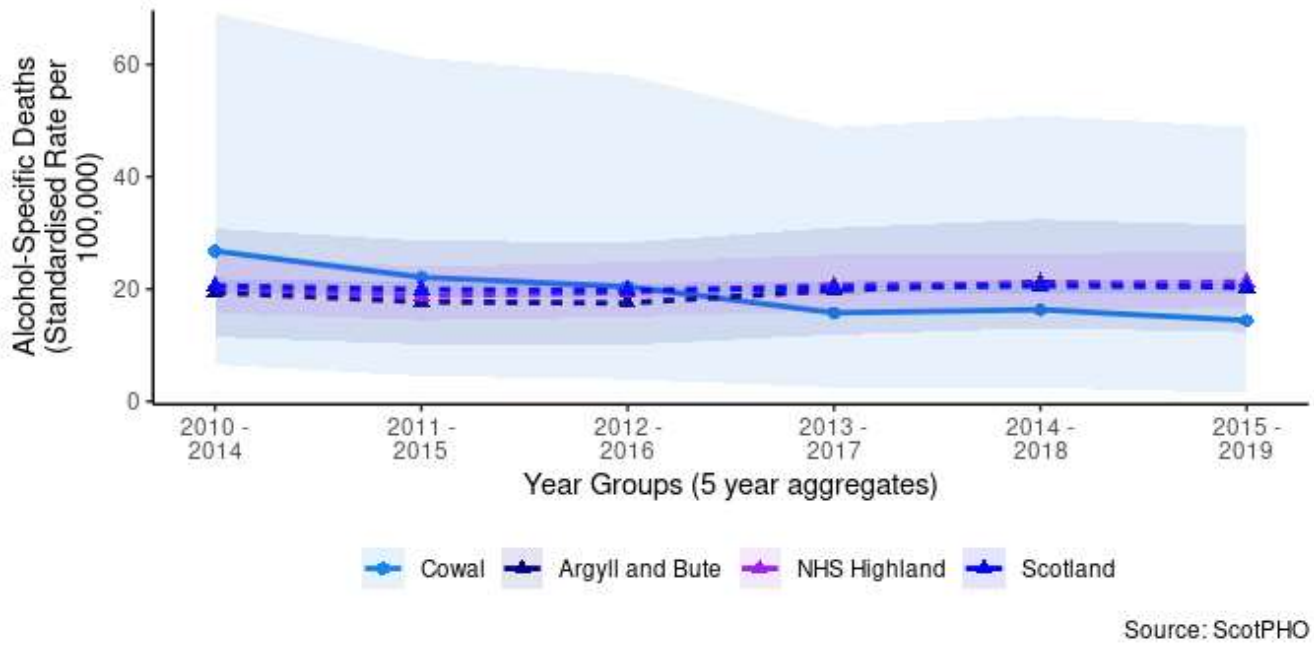
Figure 20: Comparison of Alcohol-related Hospital Admission Rates for 2019/20.



Alcohol-Specific Deaths

Data on alcohol-specific deaths is available as 5 year aggregates. The rate of alcohol-specific deaths is currently lower in Cowal than the rate in 2010 - 2014 (-46% change).

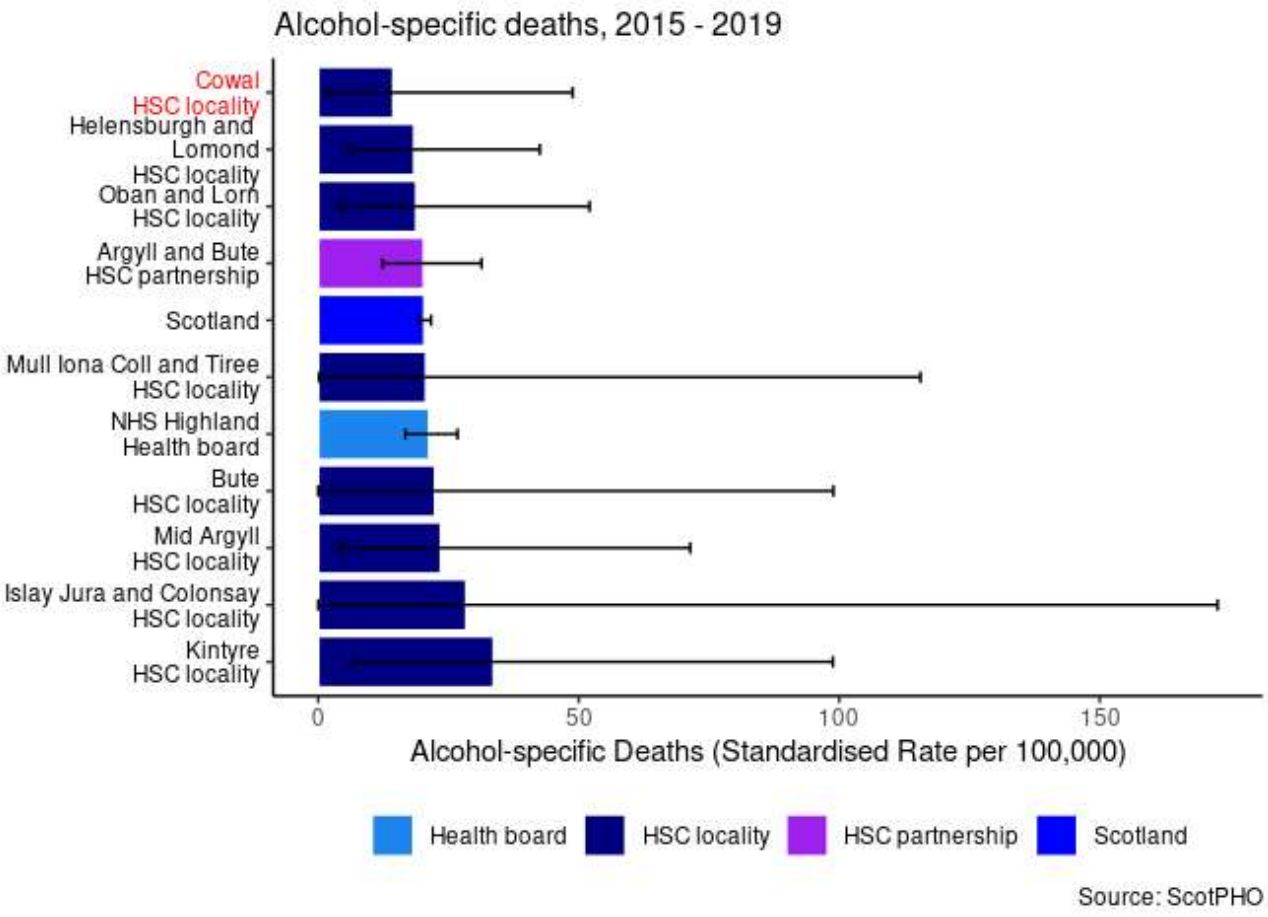
Figure 21: Trend of Alcohol-Specific Death Rates by geographical area.



Source: ScotPHO

A comparison across different areas illustrates that Cowal locality has a lower alcohol-specific death rate compared to Scotland as a whole.

Figure 22: Comparison of Alcohol-related Death Rates for the period 2015 - 2019 (5 year aggregate).

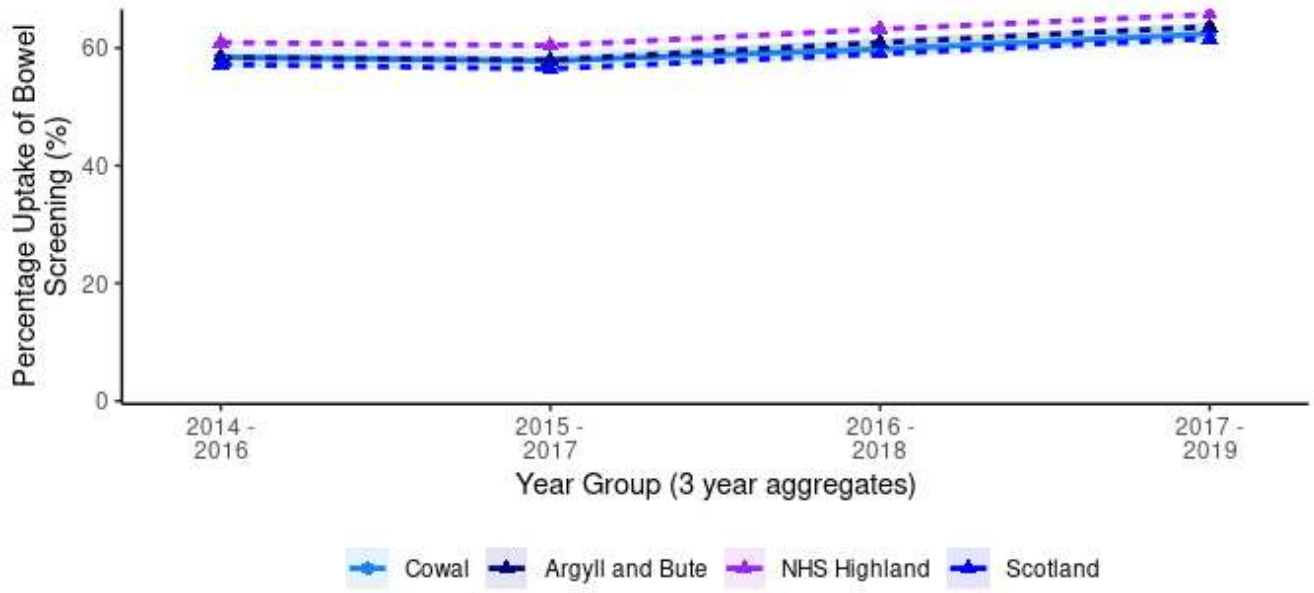


Bowel Screening Uptake

Bowel screening is offered every two years to eligible men and women aged between 50-74 years old. Eligible people are posted a test kit which is completed at home. Since 1st April 2013, those aged 75 and over can also self-refer and opt into screening.

A trend of the percentage uptake of bowel screening among the eligible population is shown below for Cowal locality compared with Scotland, Argyll and Bute HSCP and NHS Highland. Data is suppressed into 3 year aggregates. The 2017 - 2019 uptake rate for Cowal is **62%**.

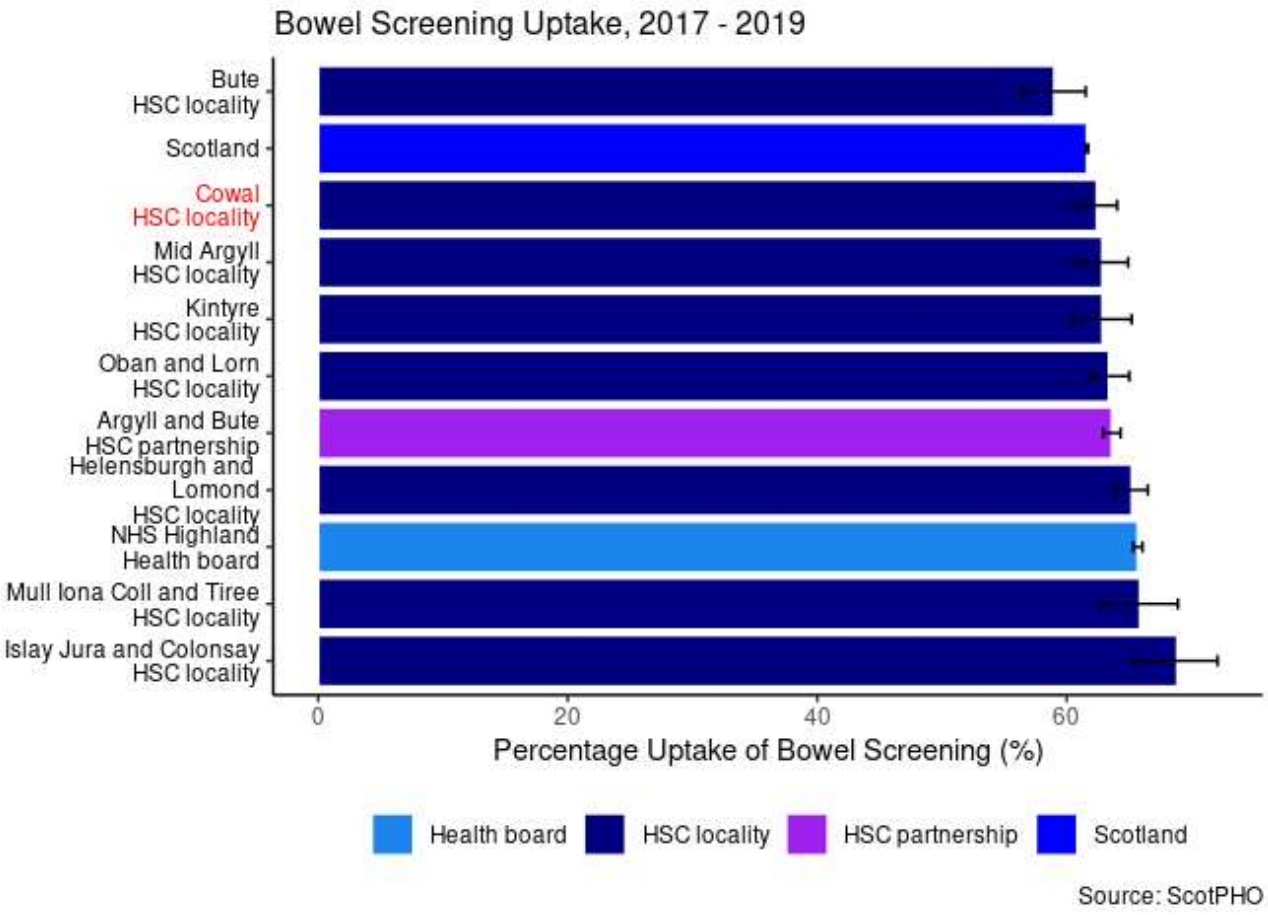
Figure 23: Trend of Bowel Screening Uptake for eligible men and women, by geographical area.



Source: ScotPHO

Compared with Scotland, Cowal locality has a higher percentage uptake of bowel cancer screening for the period 2017 - 2019.

Figure 24: Comparison of Bowel Screening Uptake for 2017 - 2019.



Hospital and Community Care

This section includes acute hospital data, delayed discharge bed days and A&E attendances. Please note that for 2020 onwards, hospital activity would have been severely affected by the COVID-19 pandemic. Information on how this has had a wider impact is provided in Footnote 6 at the end of the document.

For the most recent time periods available, Cowal had:

- **9,890** emergency hospital admissions per 100,000 population.
- **81,183** unscheduled acute specialty bed days per 100,000 population.
- **4,645** A&E attendances per 100,000 population.
- **9,291** delayed discharge bed days per 100,000 population.
- **921** emergency hospital admissions from falls per 100,000 population.
- **88** emergency readmissions (28 day) per 1,000 discharges.
- **1,249** potentially preventable hospital admissions per 100,000 population.
- People on average spent **93%** of their last 6 months of life in a community setting.

Emergency Admissions

Figure 25: Emergency admissions by age group

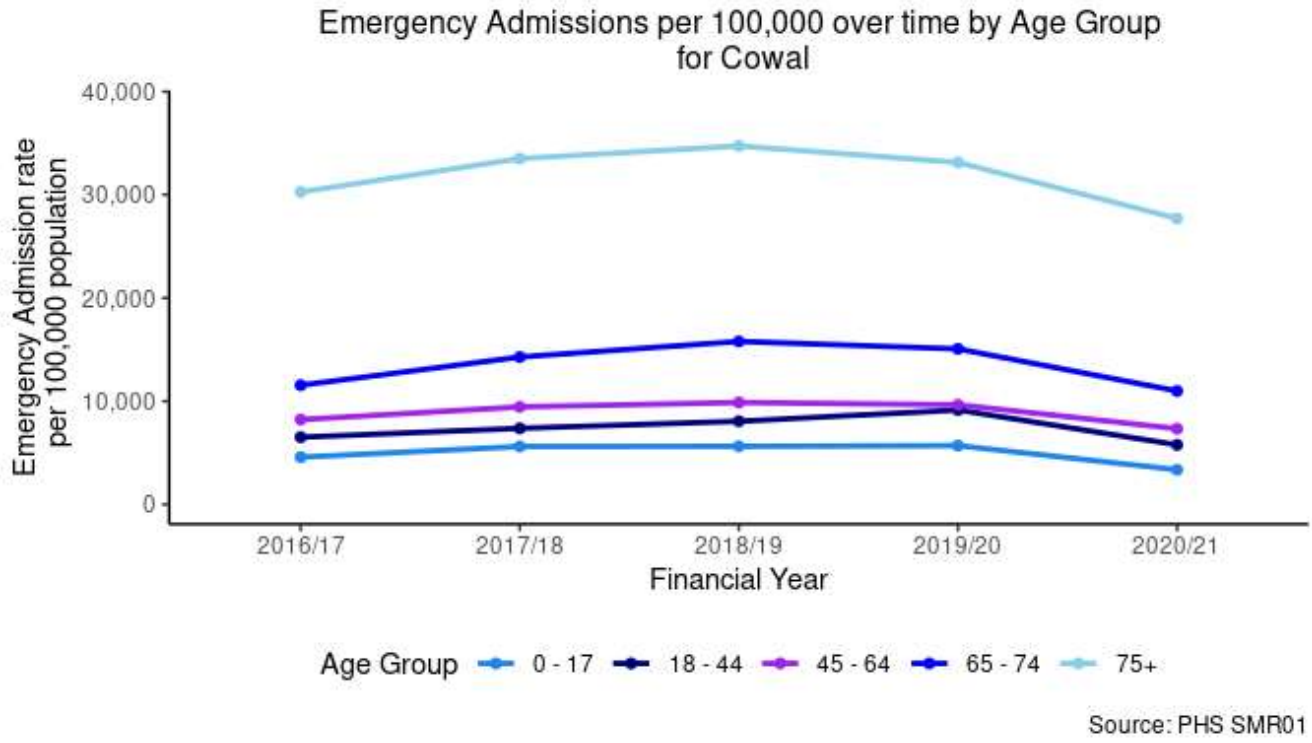
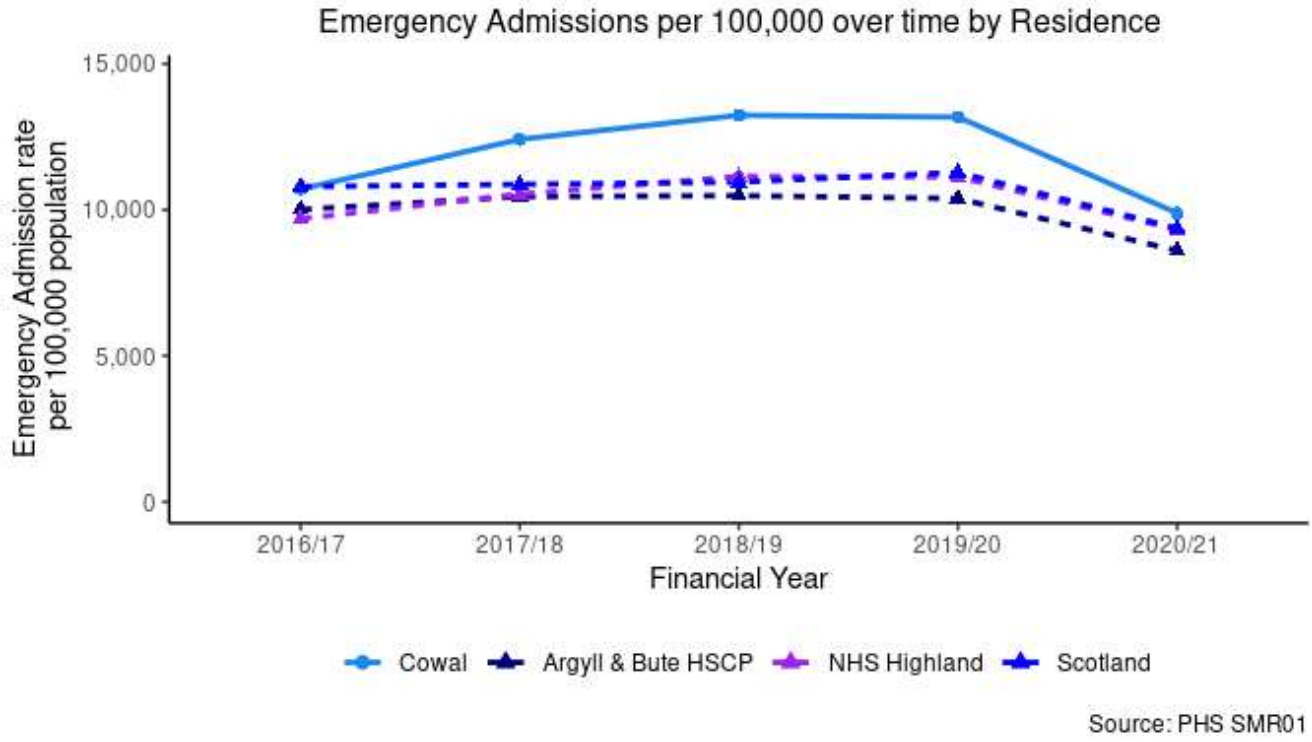
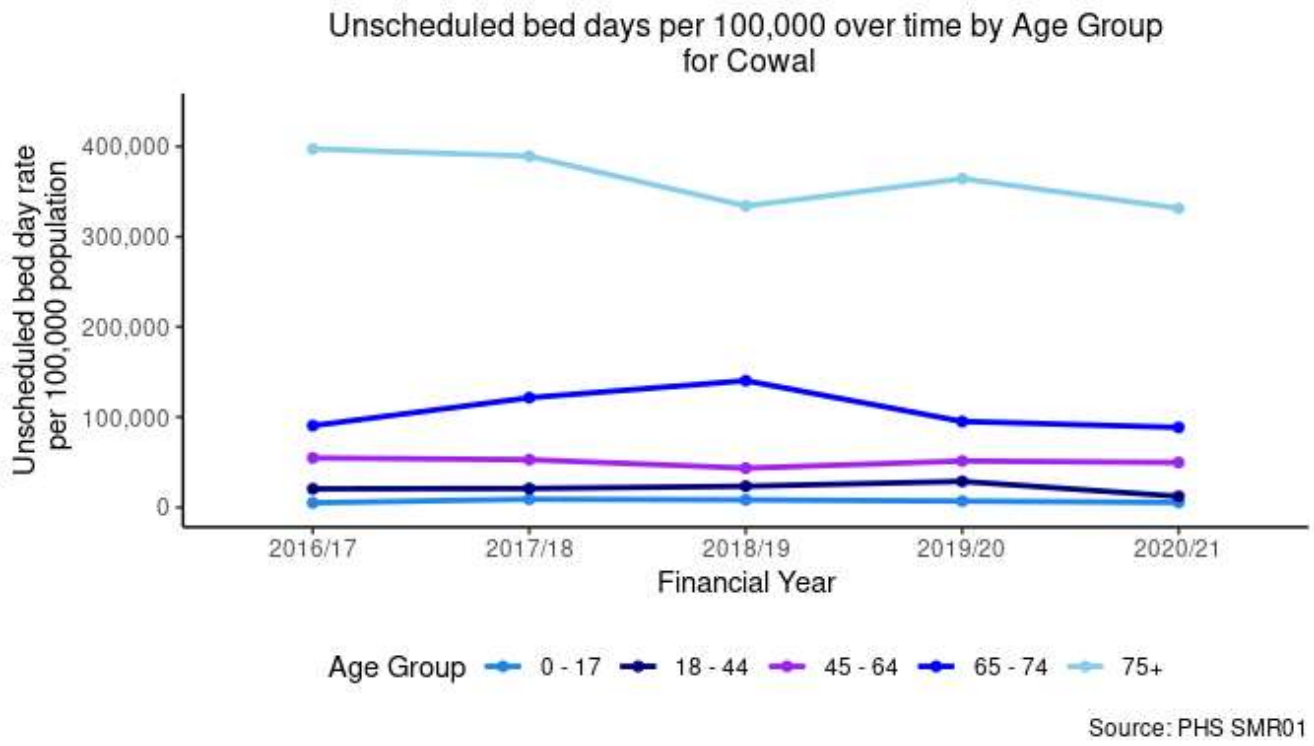


Figure 26: Emergency admissions by geographical area



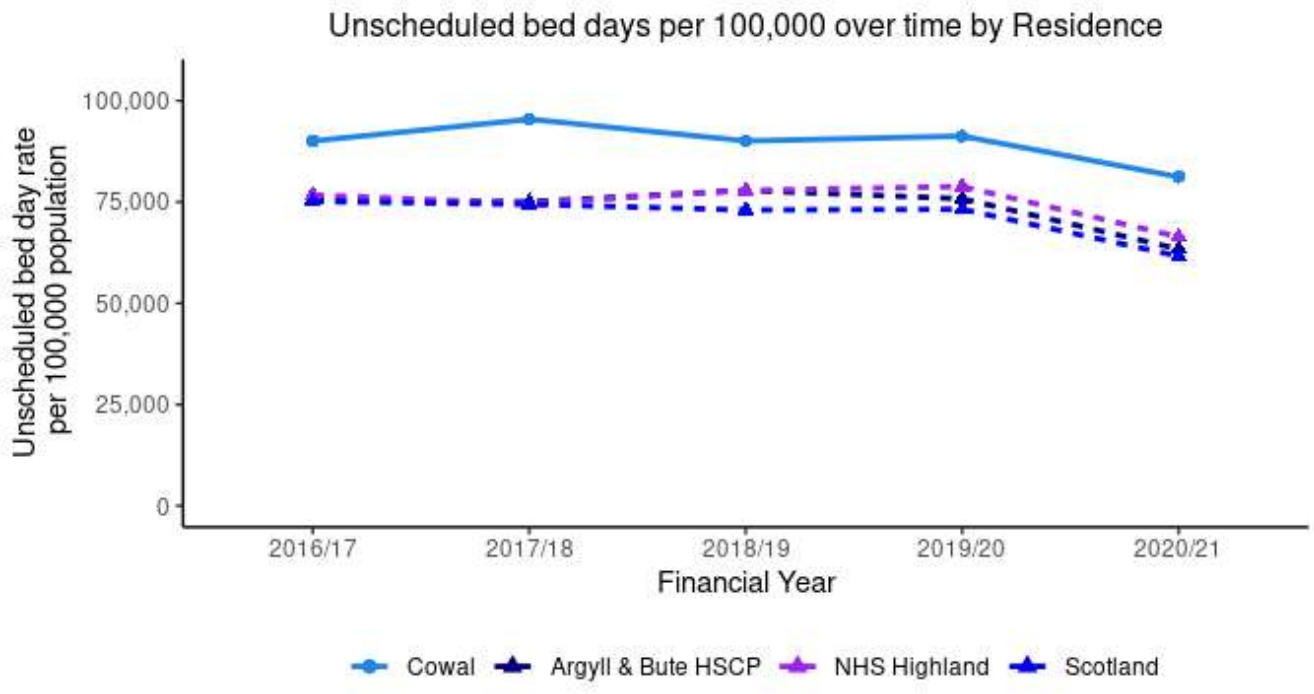
Unscheduled Acute Bed Days

Figure 27: Unscheduled bed days by age group



Source: PHS SMR01

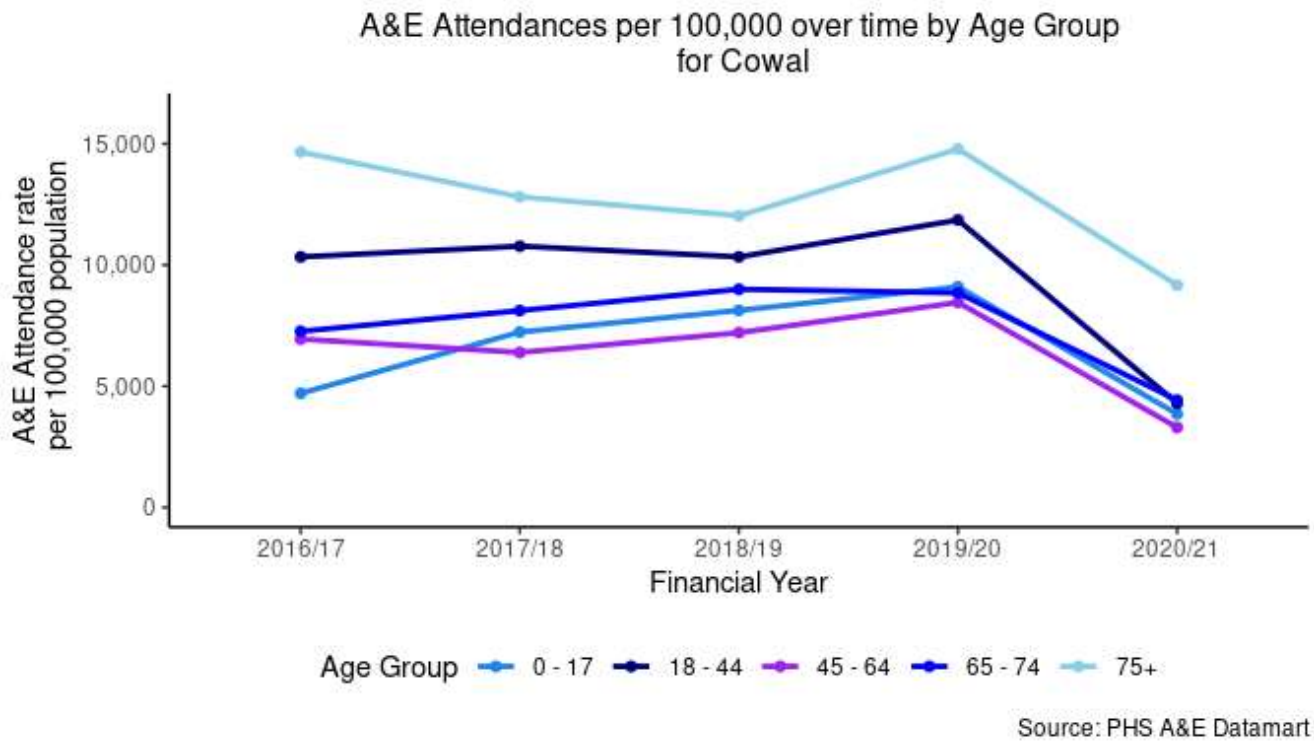
Figure 28: Unscheduled bed days by geographical area



Source: PHS SMR01

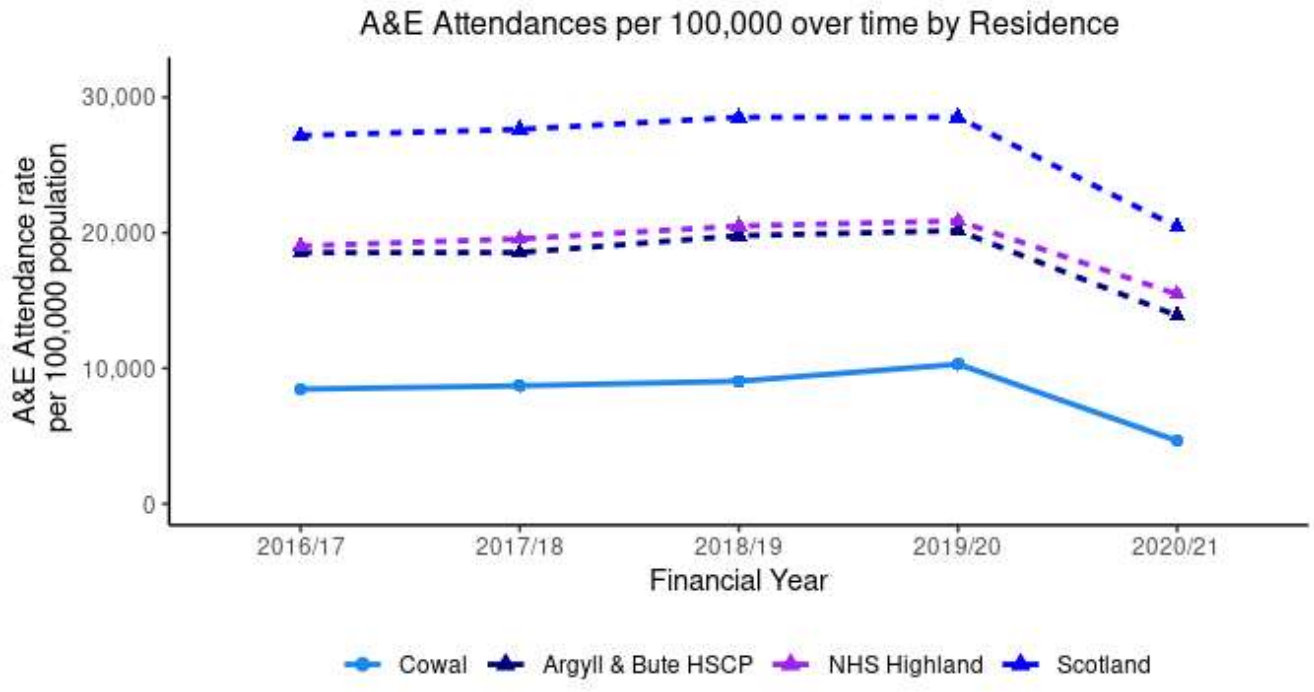
A&E Attendances

Figure 29: A&E attendances by age group



Source: PHS A&E Datamart

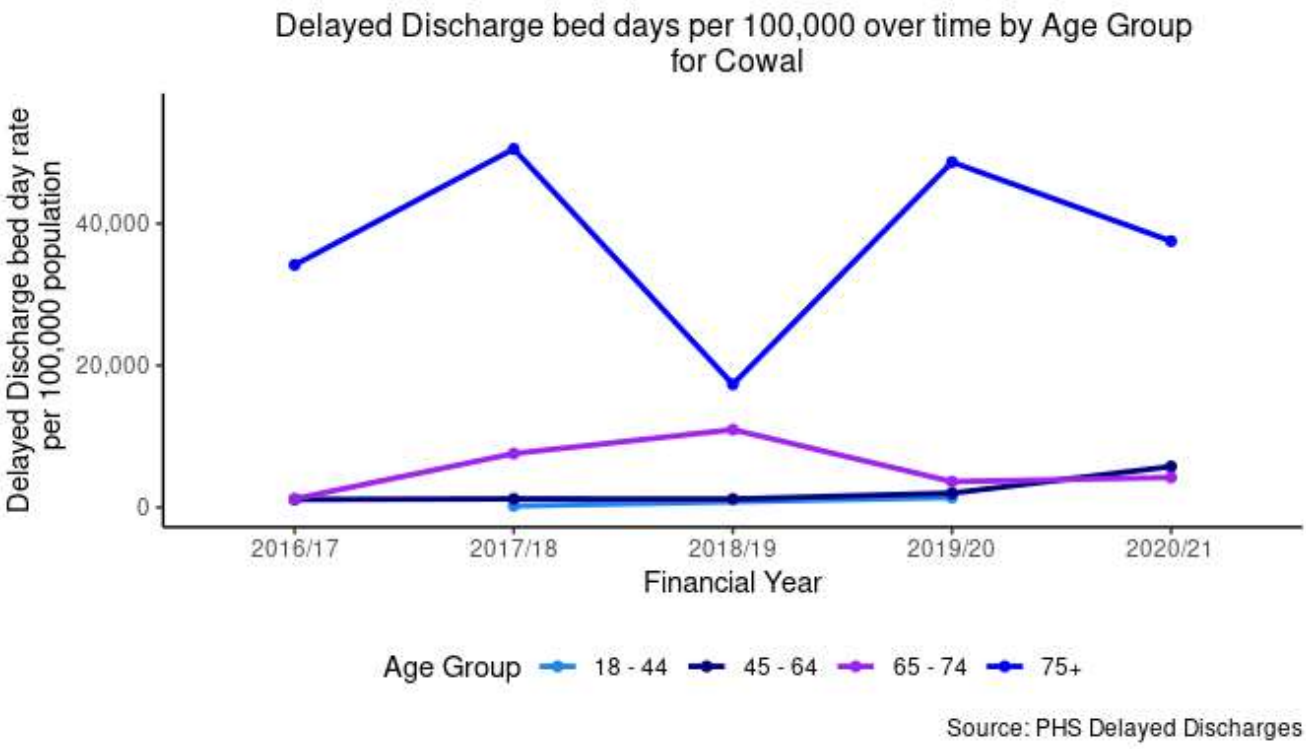
Figure 30: A&E attendances by geographical area



Source: PHS A&E Datamart

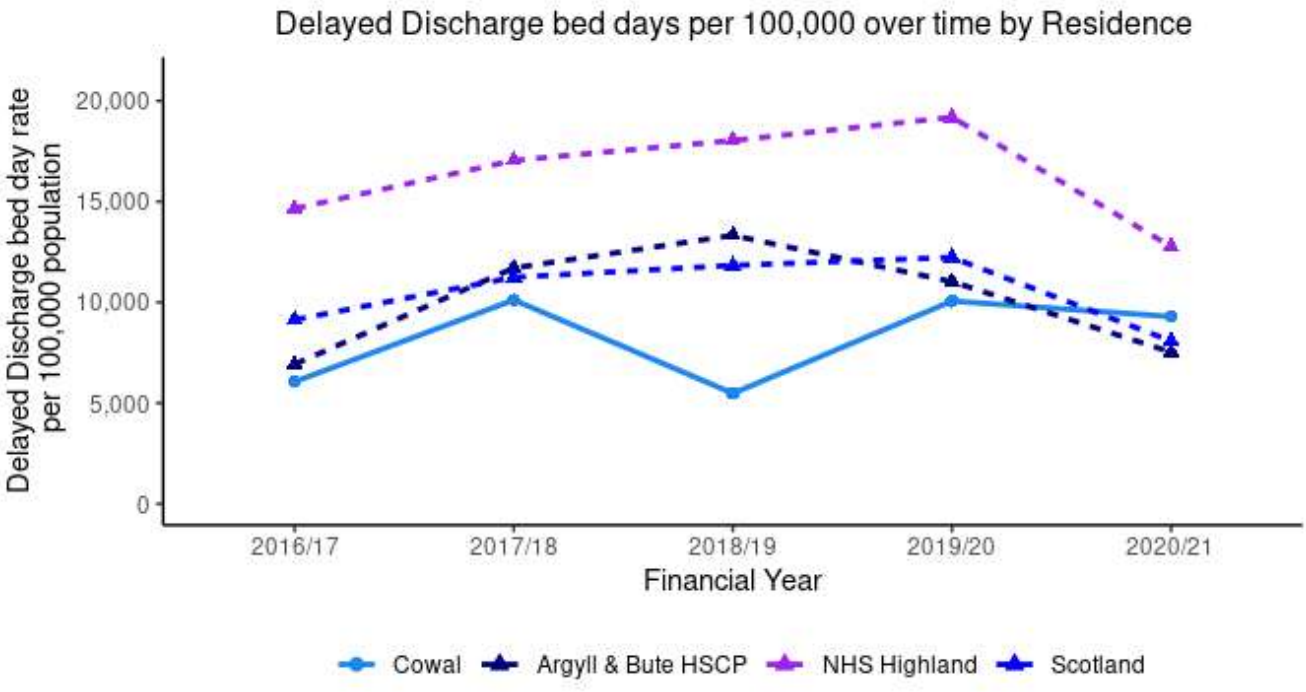
Delayed Discharge Bed Days

Figure 31: Delayed discharge bed days by age group



Source: PHS Delayed Discharges

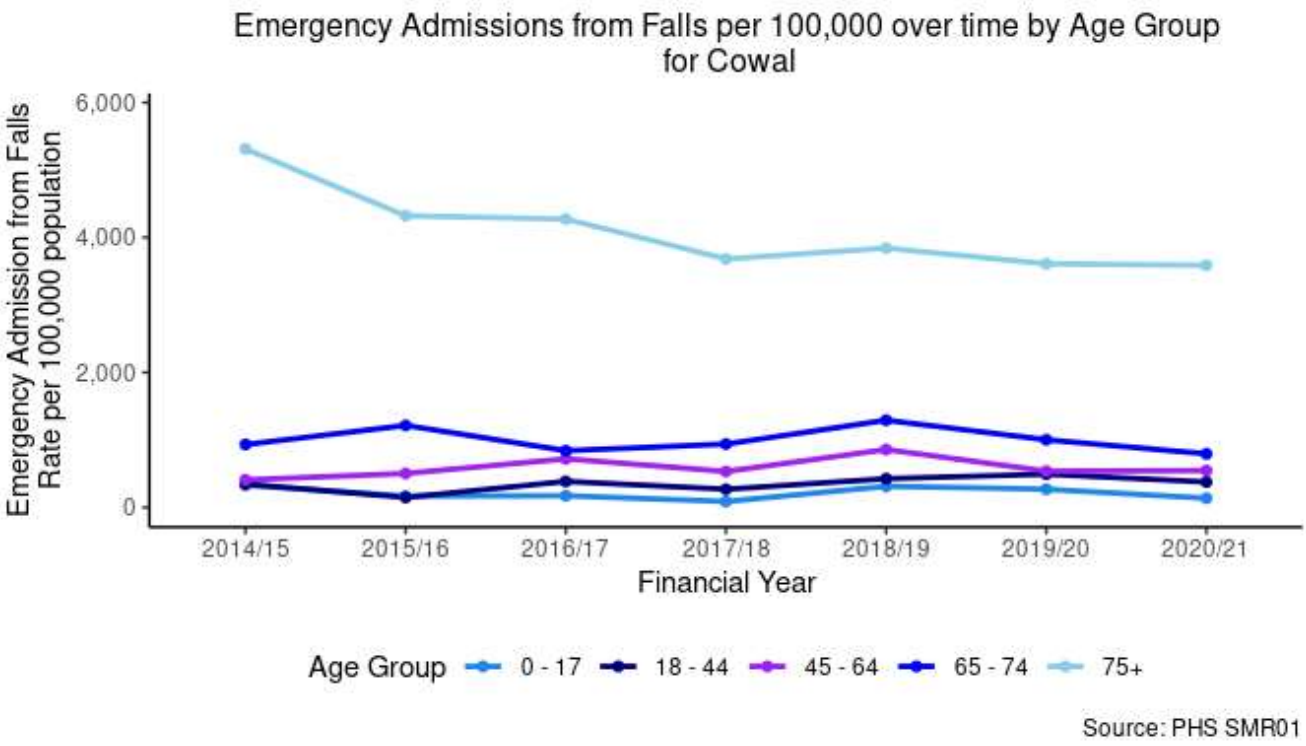
Figure 32: Delayed discharge bed days by geographical area



Source: PHS Delayed Discharges

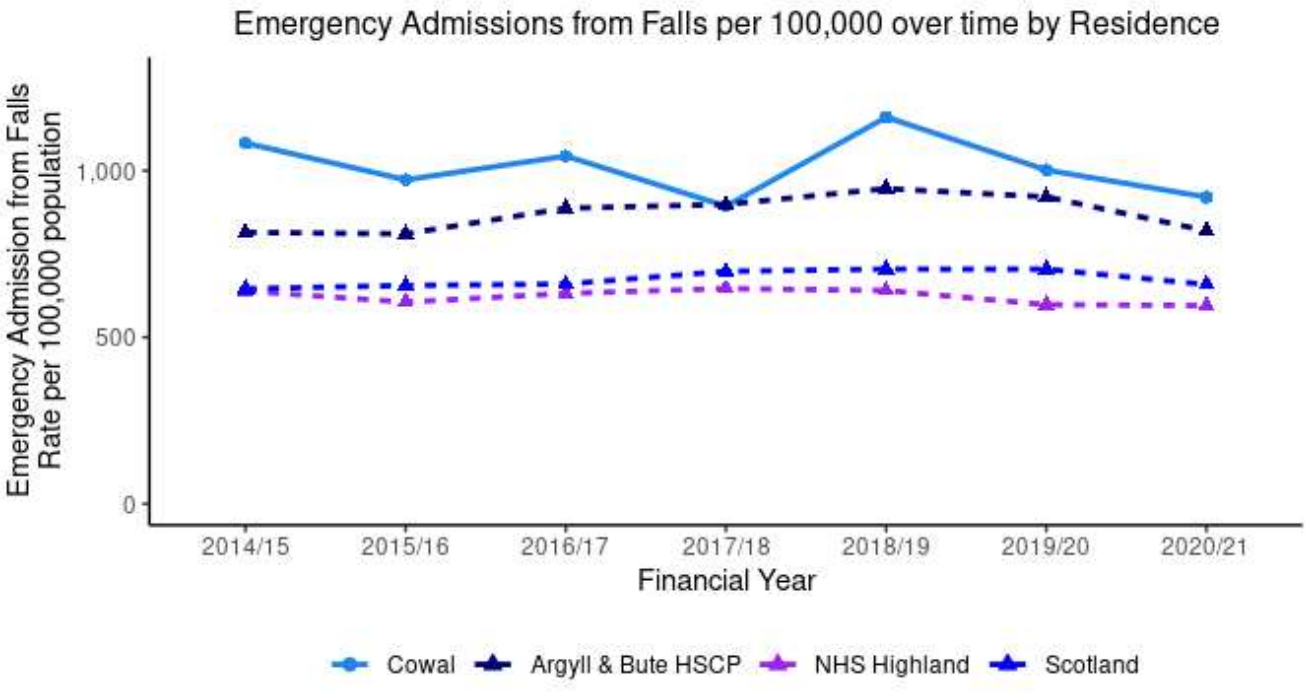
Emergency Admissions from a Fall

Figure 33: Falls by age group



Source: PHS SMR01

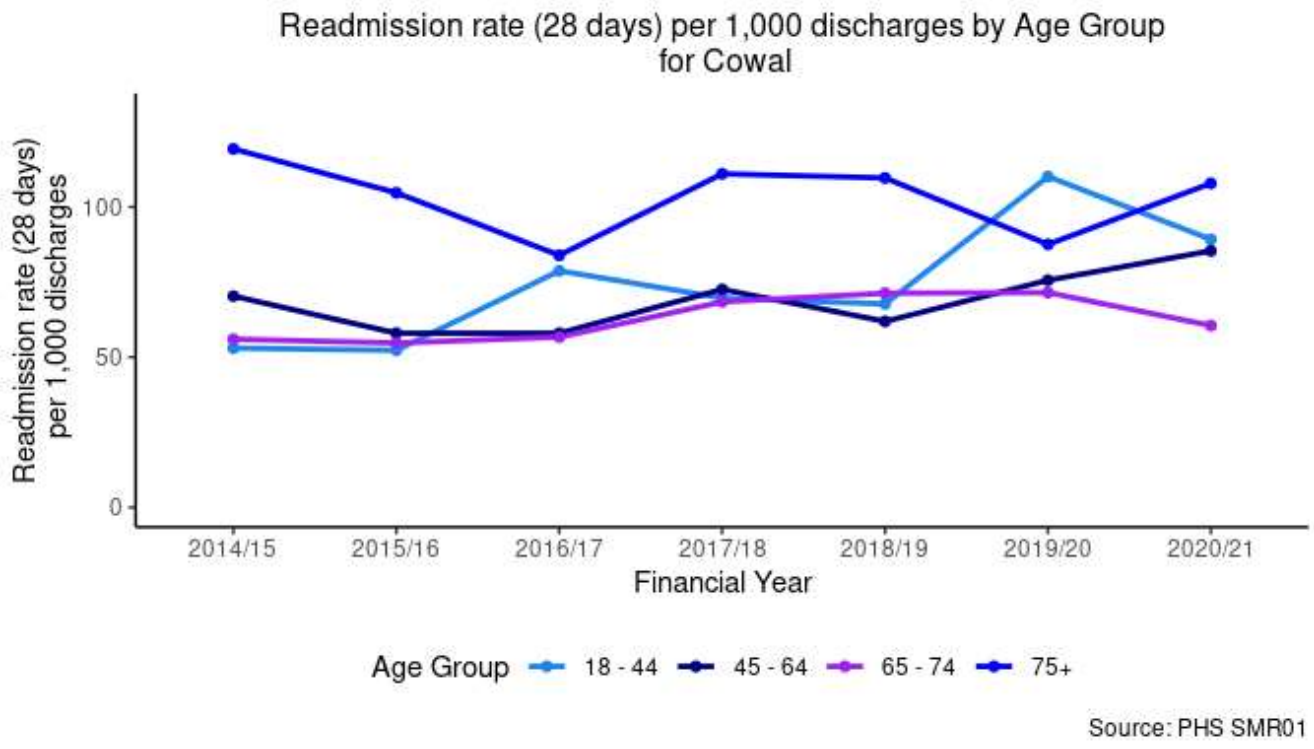
Figure 34: Falls by geographical area



Source: PHS SMR01

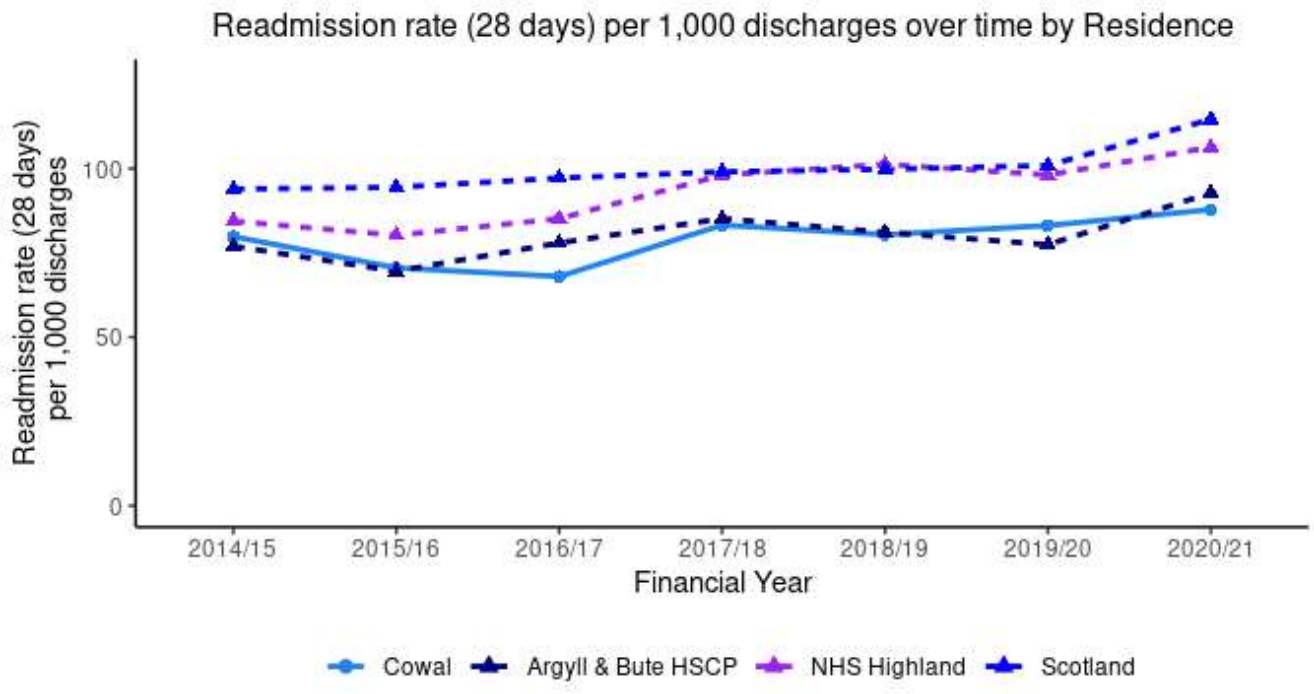
Emergency Readmissions (28 days)

Figure 35: Emergency readmissions by age group



Source: PHS SMR01

Figure 36: Emergency readmissions by geographical area

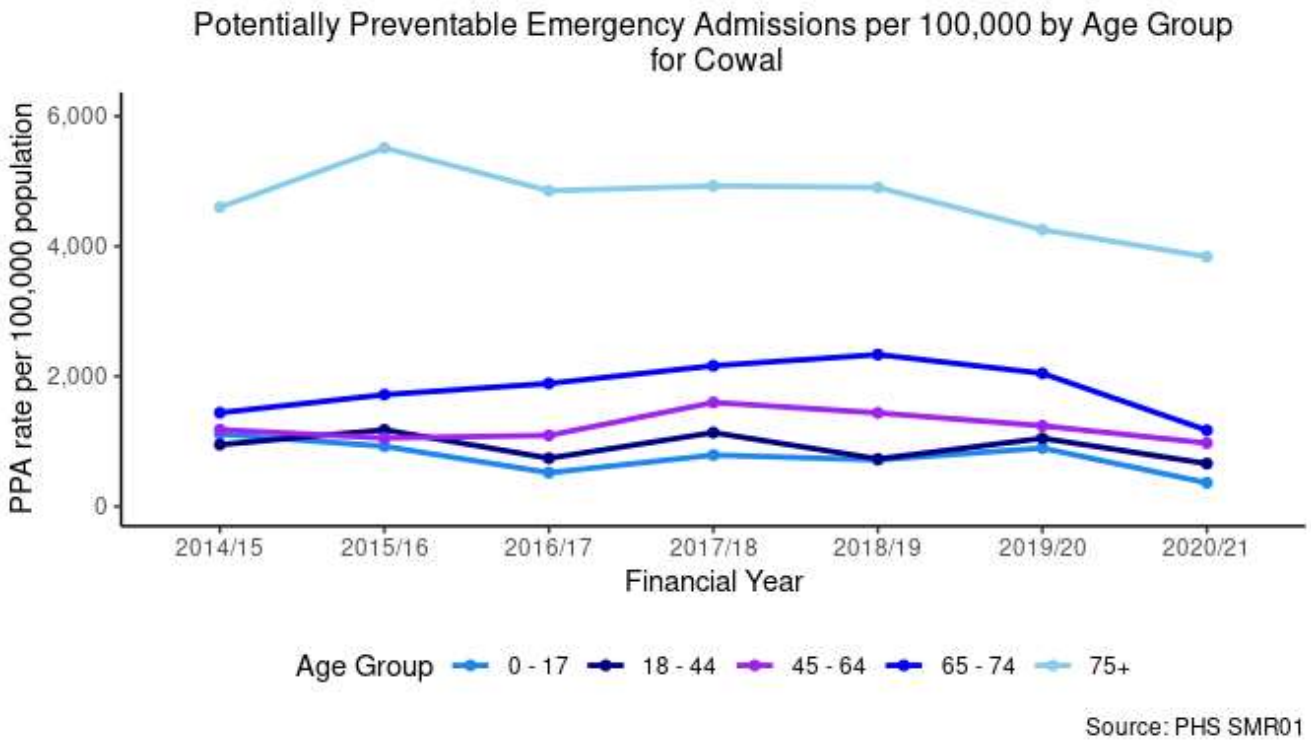


Source: PHS SMR01

Potentially Preventable Admissions (PPAs)

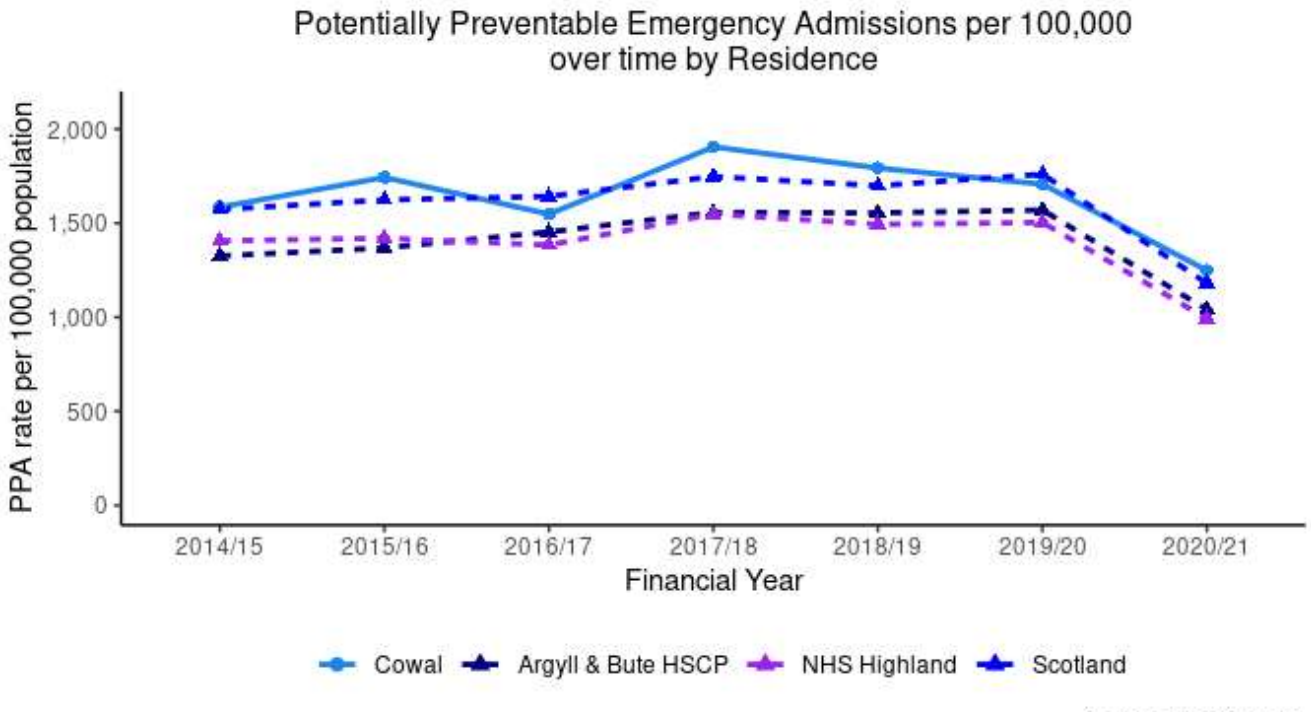
Information on which conditions are counted as PPAs is available in Appendix 3 in the accompanying summary document.

Figure 37: PPAs by age group



Source: PHS SMR01

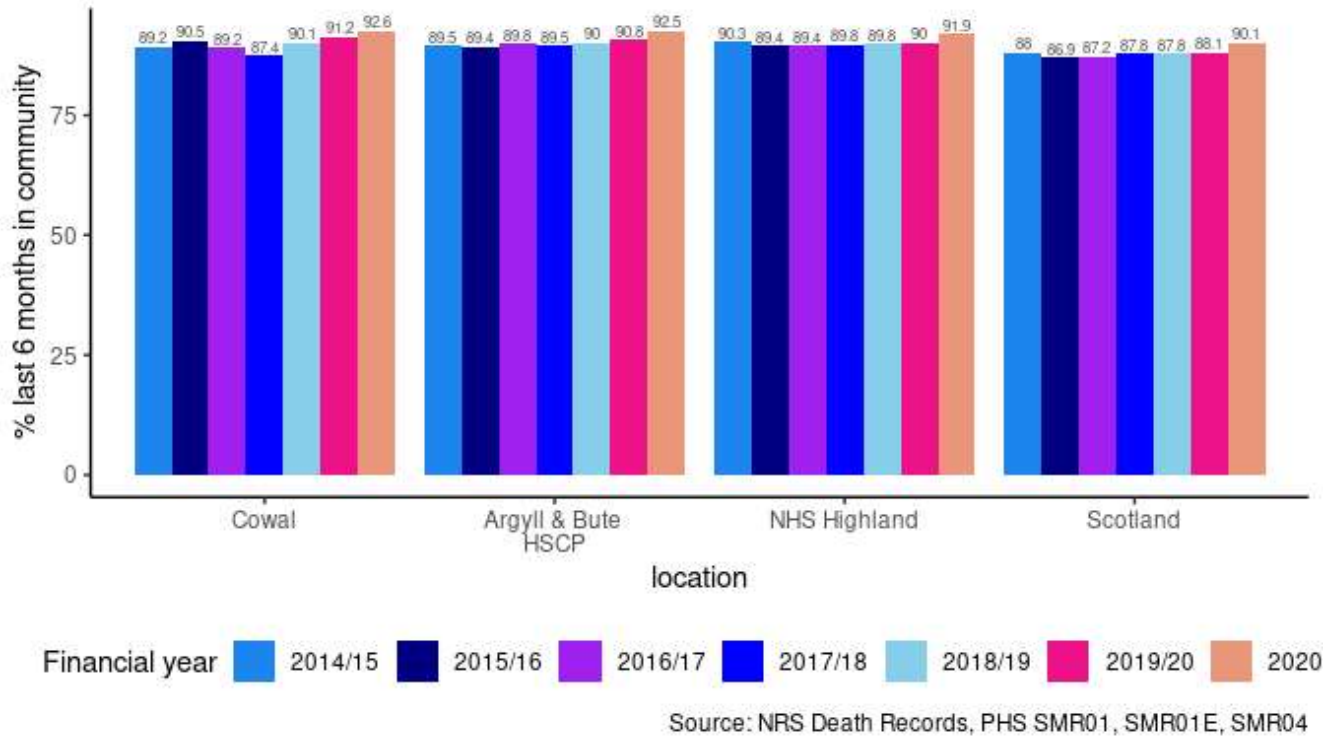
Figure 38: PPAs by geographical area



Source: PHS SMR01

% Last 6 months in a Community Setting

Figure 39: Last 6 months in a community setting by geographical area



Source: NRS Death Records, PHS SMR01, SMR01E, SMR04

Footnotes

1. Population projections are not currently provided by NRS at the locality level. To explore how the population in Cowal is expected to change in the future, the percent changes in population projection to 2025 for Argyll and Bute by age group and gender were calculated from the NRS Local Authority Population Projections. These percent changes were then applied to the Cowal 2018 mid-year population estimates (also split by age group and gender) to obtain population projection estimates for Cowal, based on the projections for the HSCP and the current population structure of the locality.
2. Care Home Data included in the Services Map and Table was sourced from the Care Inspectorate. GP Practice data from October 2021, and Hospital and A&E data was sourced from Public Health Scotland Open Data. Only services that are within the physical boundary of the HSCP or Locality are included in the map and table, so there may be services outside Argyll and Bute which people may use but are not shown.
3. The data used in General Health and Behavioural Factors sections (except for long-term conditions) of this locality profile are taken from ScotPHO. There may be more recent data available for the indicators elsewhere.
4. Data taken from ScotPHO is often reported using the European Age-Sex Standardised Rate per 100,000. This allows for comparisons across different areas to be made. For more information on how these rates are calculated, please refer to www.isdscotland.org/Products-and-Services/GPD-Support/Population/Standard-Populations/
5. Physical long-term conditions data comes from the Source Linkage Files, and the conditions are identified using ICD-9 and ICD-10 codes in the diagnosis fields. Please note that the Source Linkage Files data only contains information on people who have had contact with the NHS through either inpatient admissions, outpatient attendances, daycase attendances, A&E attendances or through prescribed items, the data does not show all service users in Scotland who have been diagnosed with an LTC as not all of these individuals will have used these services. Also note that LTC rates are based on an adjusted population indicator in the Source Linkage Files so that population sizes are closer to the official estimates.
6. The 2020 COVID-19 pandemic will have had an effect on the most recent data available. A dashboard has been created by PHS which show the wider impacts of COVID-19 over many areas. You can access this here: https://scotland.shinyapps.io/phs-covid-wider-impact/

Locality Profile

Helensburgh and Lomond Locality

October 2021

Table of Contents

Notes for this profile:

- All years shown are calendar years unless otherwise specified.
- Upper and lower 95% confidence intervals are shown throughout this document where available. In charts, these are displayed as shaded areas either side of trend lines, or as black error bars in bar charts. Confidence intervals show the range of possible values and a certainty that the true value falls within them.
- Definitions for the indicators shown are available in Appendix 1 in the accompanying summary document.
- Any zero figures for some indicators will indicate either suppression of small data or a complete lack of data available for this locality
- Data should be interpreted with caution, particularly for areas with relatively small population sizes where indicator data is expected, by chance alone, to have higher variation than in areas of larger population size. Note that differences between areas can relate to multiple factors including, for example, underlying rates of illness, rates of diagnosis and local differences in practice e.g. in data recording.

Demographics

Summary:

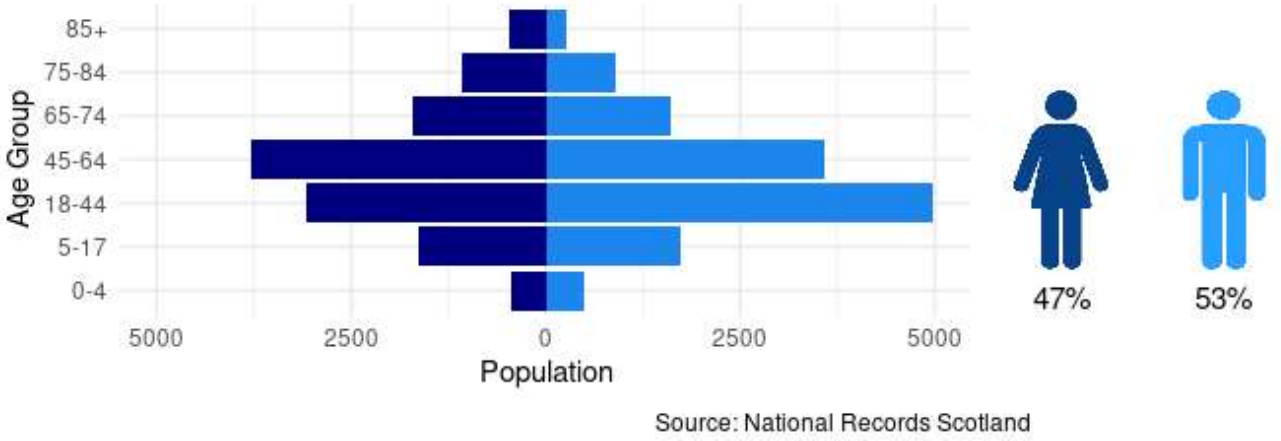
For the most recent time periods available, Helensburgh and Lomond Locality had:

- A total population of **25,715** people, where **53%** were male, and **23%** were aged over 65.
- **33%** of people lived in the least deprived SIMD quintile, and **7.3%** lived in the most deprived quintile.

Population

In 2020, the total population of Helensburgh and Lomond locality was 25,715. The graph below shows the population distribution of the locality.

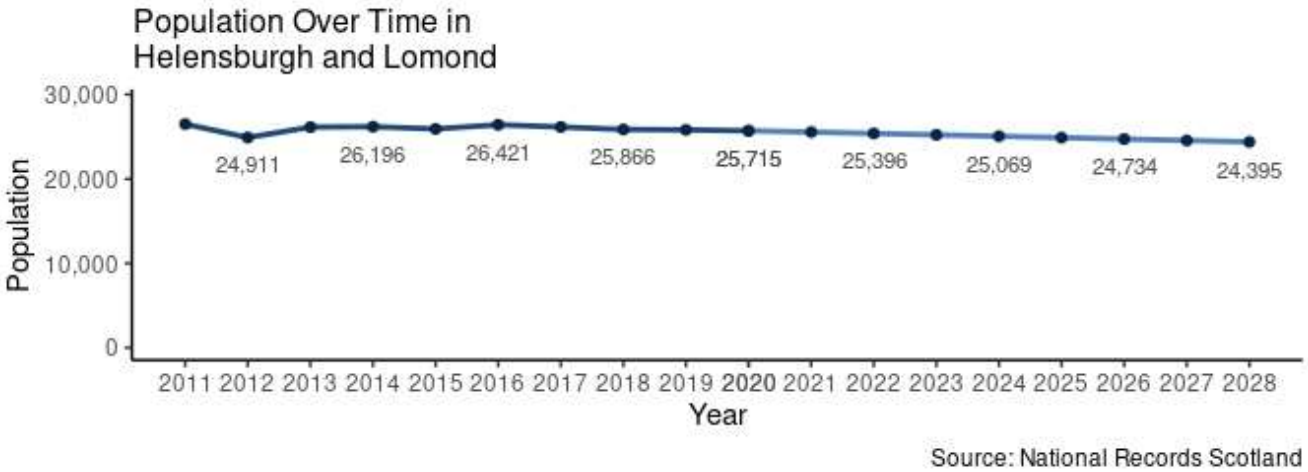
Figure 1: Population breakdown in Helensburgh and Lomond.



Source: National Records Scotland

Figure 2 shows the historical population of Helensburgh and Lomond, along with the NRS population projections. There is no significant linear trend in population. However, it has been falling since 2016. The population in Helensburgh and Lomond is estimated to decrease by 3.2% from 2020 to 2025 *Please see the footnotes for more information on how the population projections were calculated*[1].

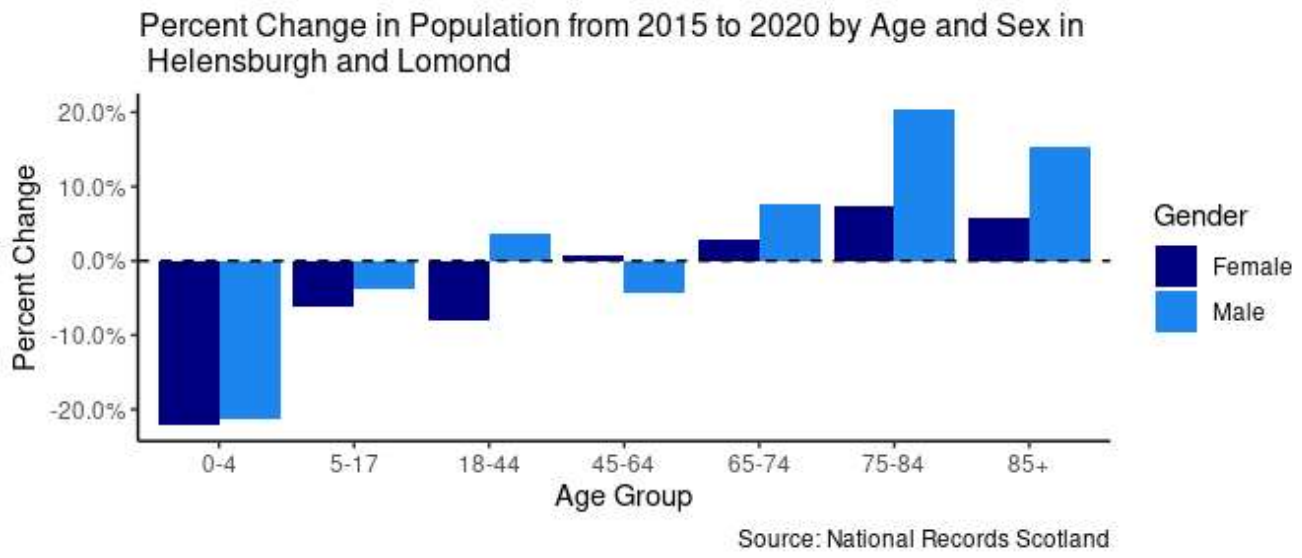
Figure 2: Population time trend and projection.



Source: National Records Scotland

Figure 3 shows how population structure has changed between 2015 and 2020.

Figure 3: Change in population structure over the last five years.



Deprivation

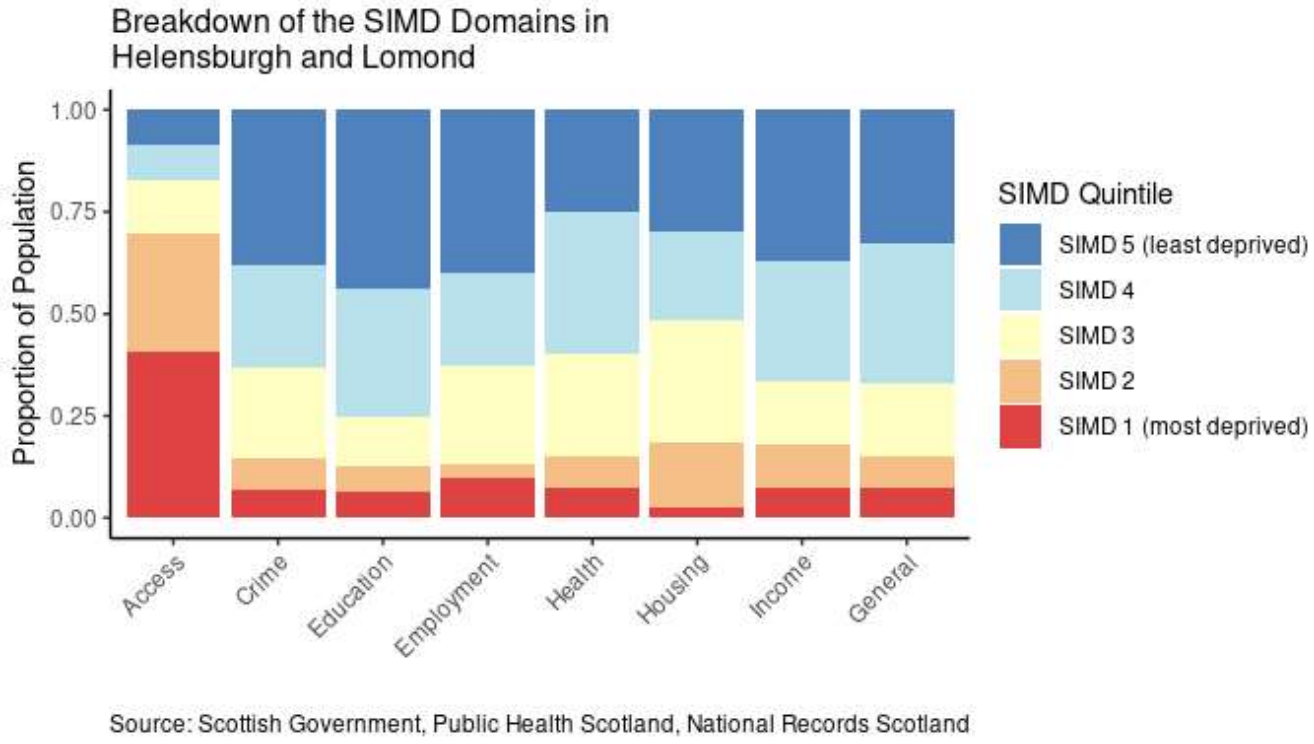
The following section explores the deprivation structure of Helensburgh and Lomond through the Scottish Index of Multiple Deprivation (SIMD). The SIMD ranks all datazones in Scotland by a number of factors; Access, Crime, Education, Employment, Health, Housing and Income. Based on these ranks, each datazone is then given an overall deprivation rank, which is used to split datazones into Deprivation Quintiles (Quintile 1 being the most deprived, and Quintile 5 the least). The most recent SIMD ranking was carried out in 2020. This section mainly focuses on the SIMD 2020 classifications, however the 2016 classifications are used to assess how deprivation has changed in Helensburgh and Lomond when compared to the rest of Scotland.

Of the 2020 population in Helensburgh and Lomond, **7.3%** live in the most deprived SIMD Quintile, and **33%** live in the least deprived SIMD Quintile. The following table details the percent of the population living in the 2016 SIMD Quintiles, the percent living in the 2020 SIMD Quintiles, and their difference for comparison.

Table 1: Percentage population living in the 2016 and 2020 SIMD Datazone Quintiles

Quintile	Percent of Pop (2016)	Percent of Pop (2020)	Difference
SIMD 1	7.6%	7.3%	-0.3%
SIMD 2	5.9%	7.8%	1.9%
SIMD 3	15.5%	17.7%	2.2%
SIMD 4	38.3%	34.3%	-4.0%
SIMD 5	32.6%	32.8%	0.2%

Figure 4: Proportion of the population that reside in each 2020 SIMD quintile by domain.



Source: Scottish Government, Public Health Scotland, National Records Scotland

Households

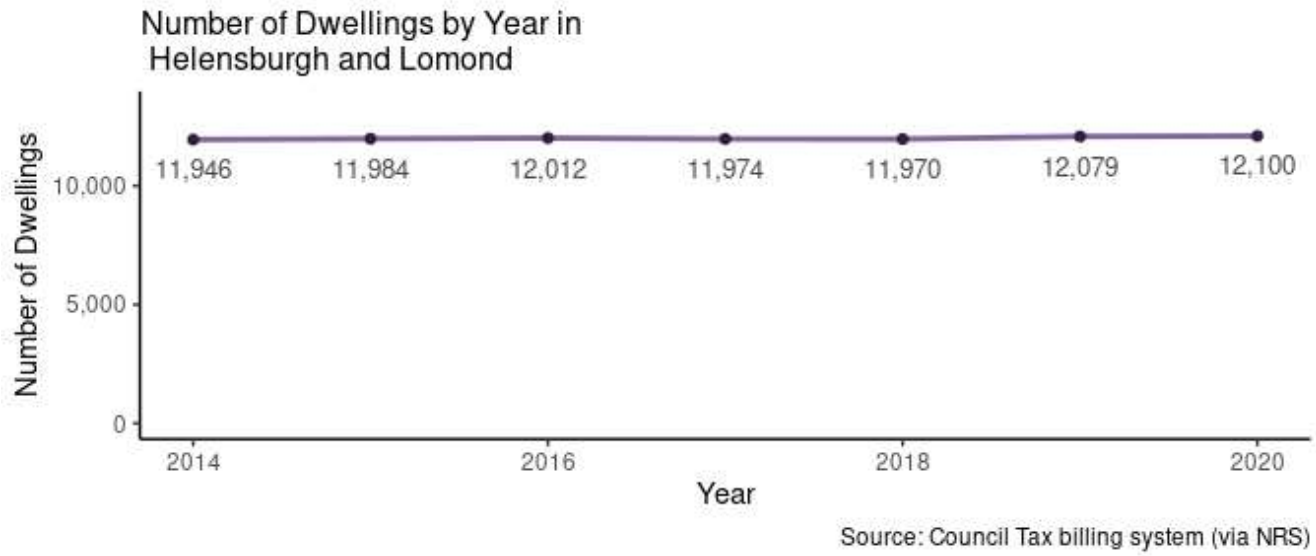
Summary:

For the most recent time periods available, Helensburgh and Lomond Locality had:

- **12,100** dwellings, of which: **95%** were occupied and **1.5%** were second homes.
- **32%** of dwellers received a single occupant council tax discount, and **5.7%** were exempt from council tax entirely.
- **41%** of houses were within council tax bands A to C, and **29%** were in bands F to H.

The graph below shows the number of dwellings in Helensburgh and Lomond from 2014 to 2020.

Figure 5: Number of dwellings time trend.



Of the total number of dwellings in 2020, 32% (3,812 households) were occupied by an individual receiving a single occupant council tax discount. Furthermore, 5.7% (692 households) were occupied and exempt from council tax.

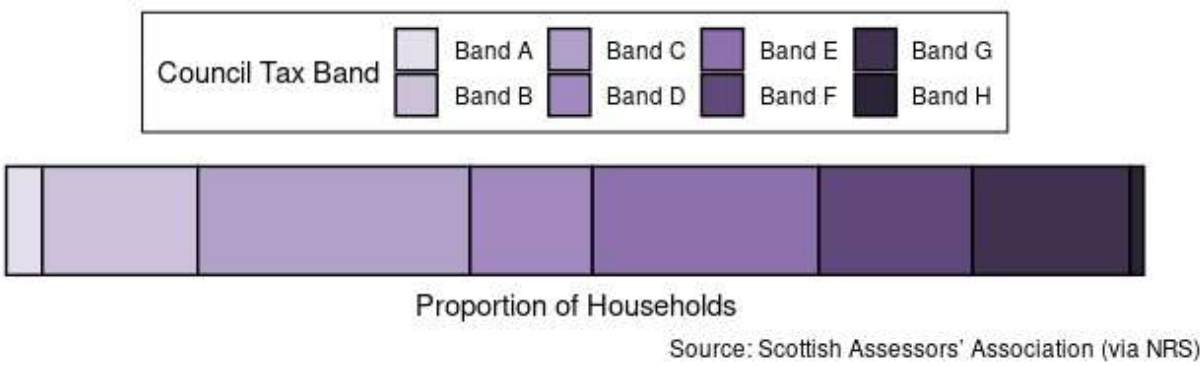
There were 176 dwellings classed as a second home in 2020, these dwellings made up 1.5% of the households in Helensburgh and Lomond.

Table 2: Breakdown of dwelling types by year for Helensburgh and Lomond locality.

Year	Total Dwellings	Occupied Dwellings	Vacant Dwellings	Single Occupant Tax Discount	Council Tax Exempt Dwellings	Second Homes
2014	11,946	11,264	465	3,715	738	217
2015	11,984	11,323	446	3,722	758	215
2016	12,012	11,386	422	3,762	759	204
2017	11,974	11,422	355	3,714	751	197
2018	11,970	11,425	361	3,630	773	184
2019	12,079	11,549	360	3,722	773	170
2020	12,100	11,532	392	3,812	692	176

The proportion of households within each council tax band are displayed in the chart below, figures are shown in Table 3.

Figure 6: Breakdown of households by council tax band for Helensburgh and Lomond in 2020.



Source: Scottish Assessors' Association (via NRS)

Table 3: Percentage of households by council tax band for Helensburgh and Lomond in 2020.

Tax Band	A	B	C	D	E	F	G	H
Percent of households	3.2%	14%	24%	11%	20%	14%	14%	1.2%

General Health

Summary:

For the most recent time periods available[3], Helensburgh and Lomond Locality had:

- **An average life expectancy of 80 years for males and 82.5 years for females.**
- **A death rate for ages 15 to 44 of 77 deaths per 100,000 age-sex standardised population[4]**
- **21%** of the locality's population with at least one long-term physical health condition.
- A cancer registration rate of **627** registrations per 100,000 age-sex standardised population[4]
- **16.29%** of the population being prescribed medication for anxiety, depression, or psychosis.

Life Expectancy

In the latest time period available from 2016-2020 (5 year aggregate), the average life expectancy in Helensburgh and Lomond locality was 80 years old for men, and 82.5 years old for women. A time trend since 2013-2017 can be seen in figure 8.

Figure 8: Average life expectancy in men and women over time.

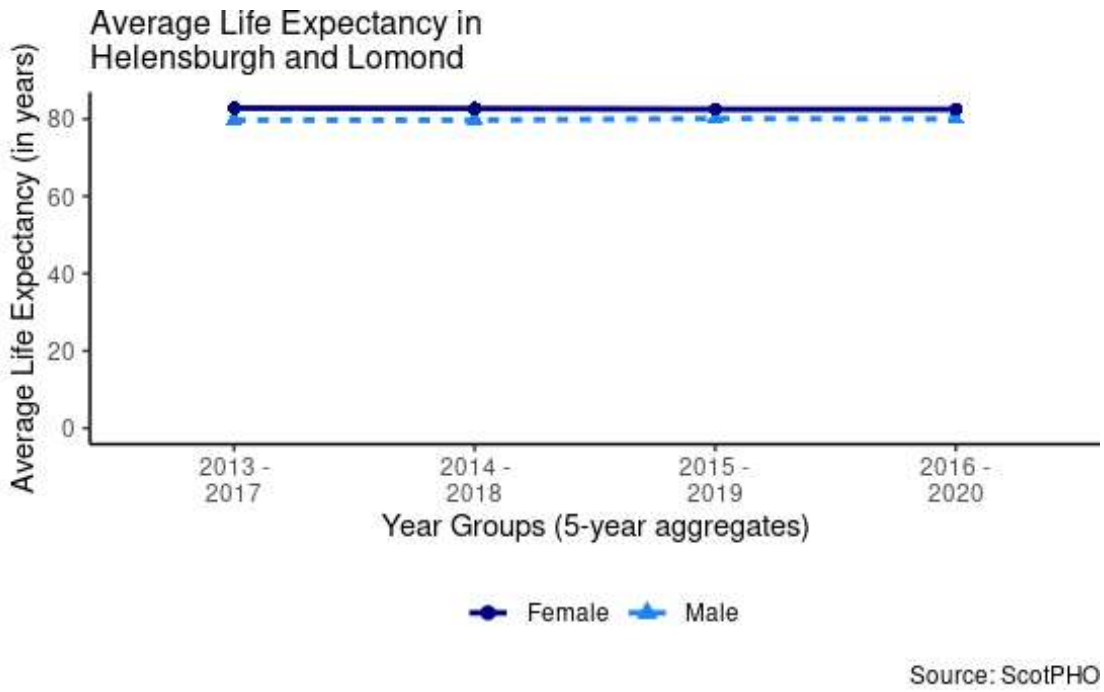


Table 5 provides the average life expectancy for men and women in different areas for the latest time period available. Please note that these are 5 year aggregates for the locality from 2016-2020, but 3 year aggregates from 2018-2020 at partnership, Health Board, and Scotland level.

Table 5: Average life expectancy in years for the latest time periods (2016-2020 aggregated years for the locality; 2018-2020 aggregated years for other areas).

	Locality	Partnership	Health Board	Scotland
	82.5	81.6	81.8	81
	80	78	77.6	76.8

Where Locality = Helensburgh and Lomond, Partnership = Argyll and Bute HSCP, Health Board = NHS Highland.

Deaths, aged 15-44

The following chart shows a trend of death rates among 15-44 year olds per 100,000 age-sex standardised population[4] by area (i.e. Early mortality rate per 100,000). In the most recent aggregate time period available (from 2018-2020), the mortality rate in Helensburgh and Lomond locality was **77** deaths per 100,000 population. Figure 10 then provides comparisons of deaths for all localities in Argyll and Bute HSCP, for the two latest time aggregates available.

Figure 9: Deaths aged 15-44 years by geographical area and over time.

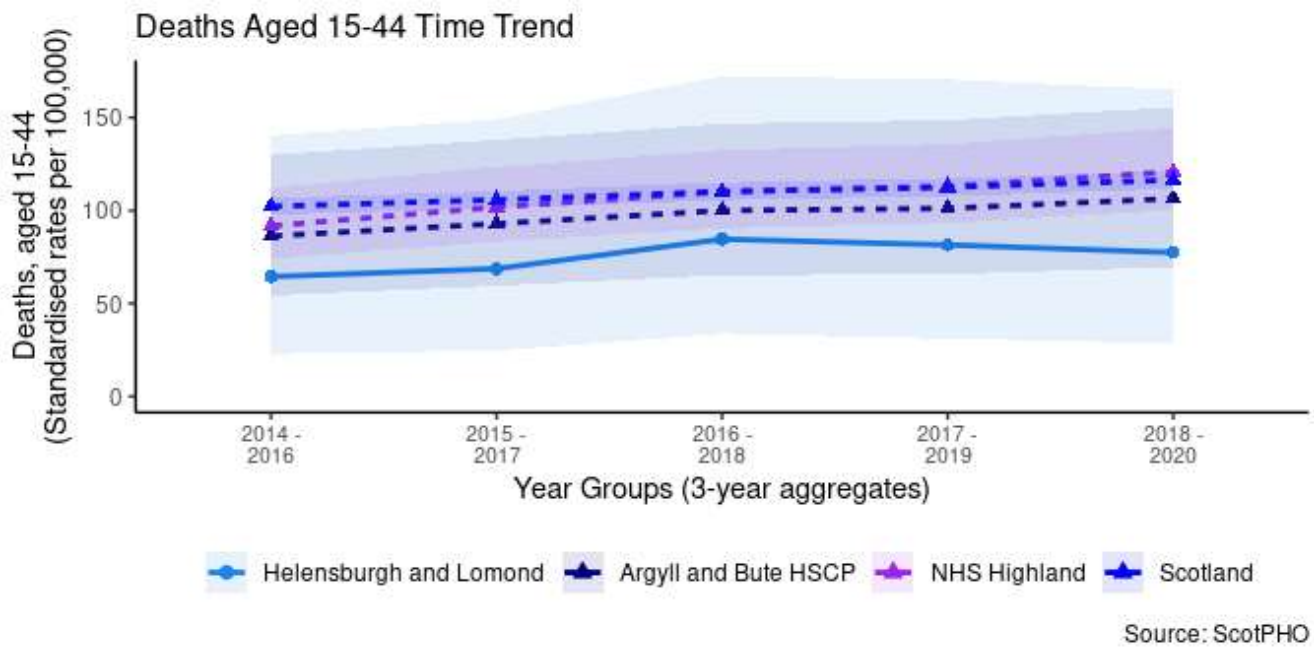
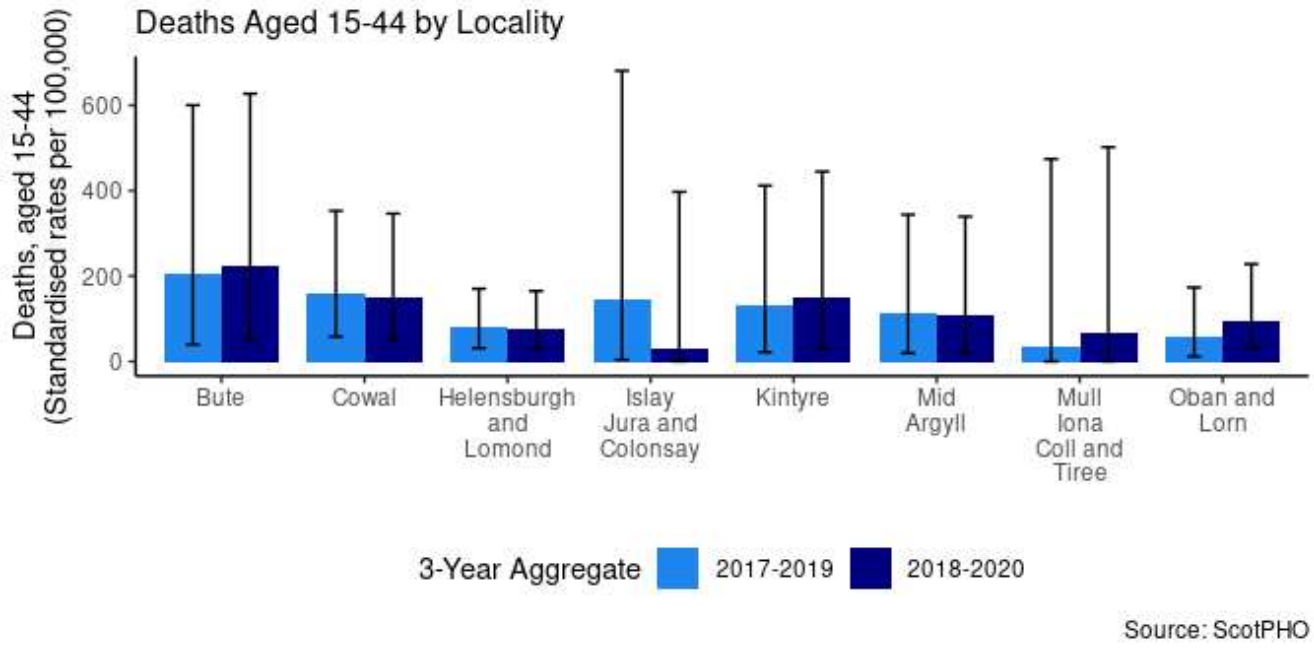
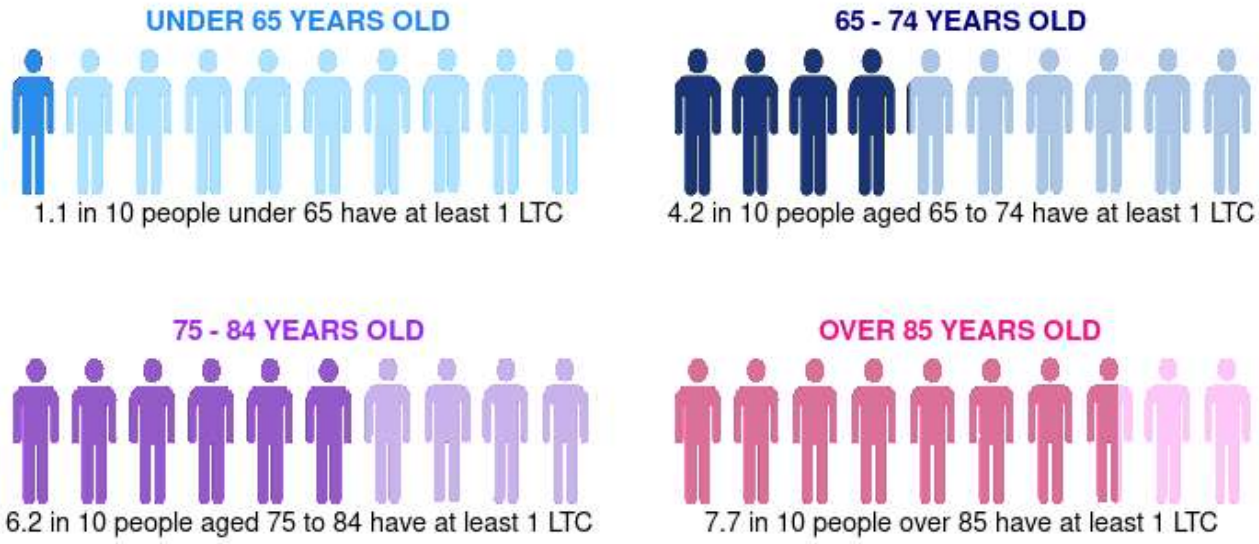


Figure 10: Deaths at ages 15-44 in Argyll and Bute HSCP localities.



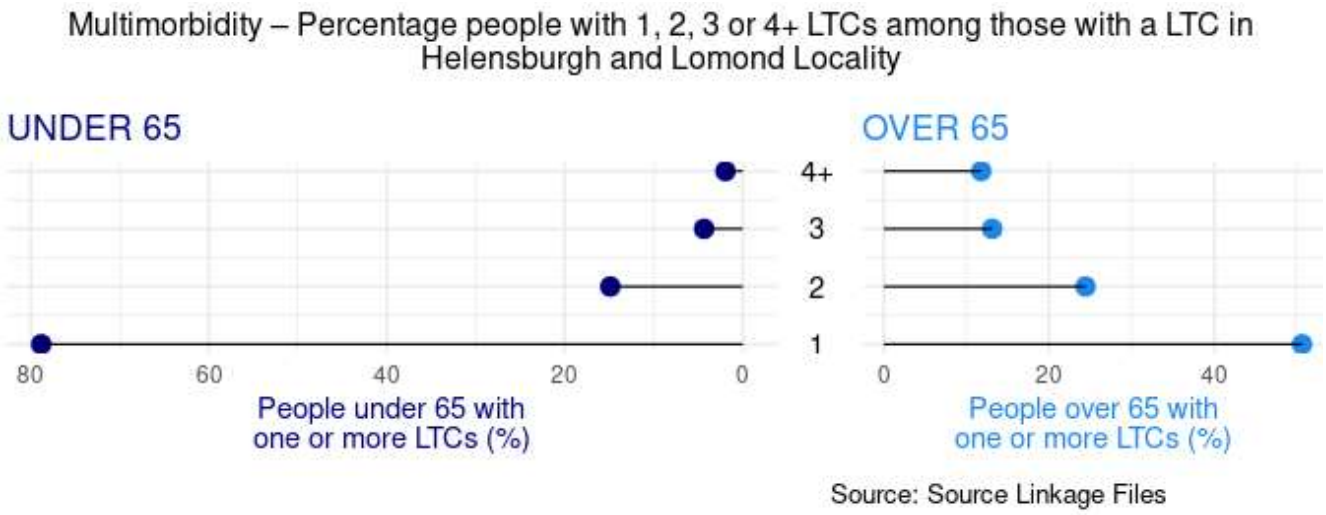
Long-Term Physical Health Conditions and Multimorbidity

In the financial year 2020/21, in Helensburgh and Lomond Locality, **21%** of the total population had at least one physical long-term condition (LTC). These include: cardiovascular, neurodegenerative, and respiratory conditions, as well as other organ conditions (namely liver disease and renal failure), arthritis, cancer, diabetes, and epilepsy. *Please see footnotes for information and caveats on identifying LTCs.*[5]



The co-occurrence of two or more conditions, known as multimorbidity, is broken down in figure 11, distinguishing between age groups. Note that this chart *excludes* the population in the locality who do not have any physical long-term conditions. Figure 13 therefore shows that among the people who have a LTC, **21**% of those under the age of 65 have more than one, compared to **49**% of those aged over 65.

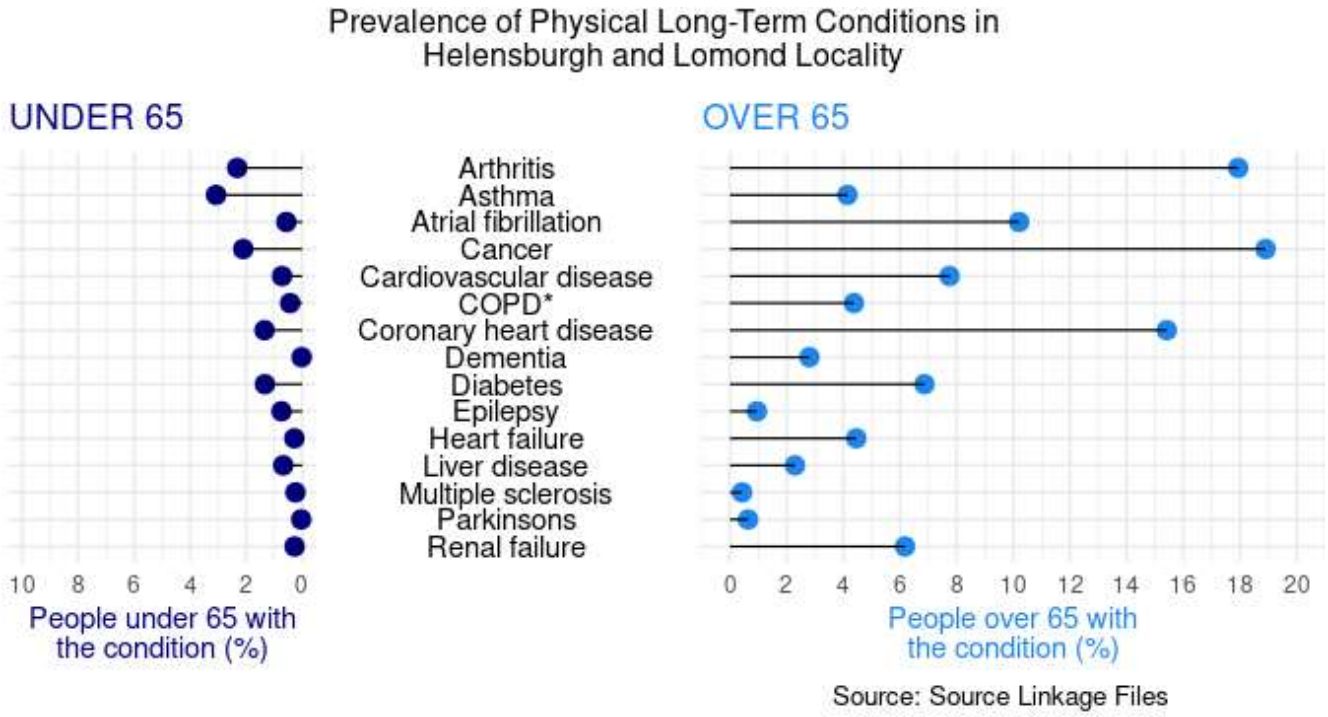
Figure 11: Multimorbidity of physical long-term conditions by age group in 2020/21.



Most common physical Long-Term Conditions (LTCs)

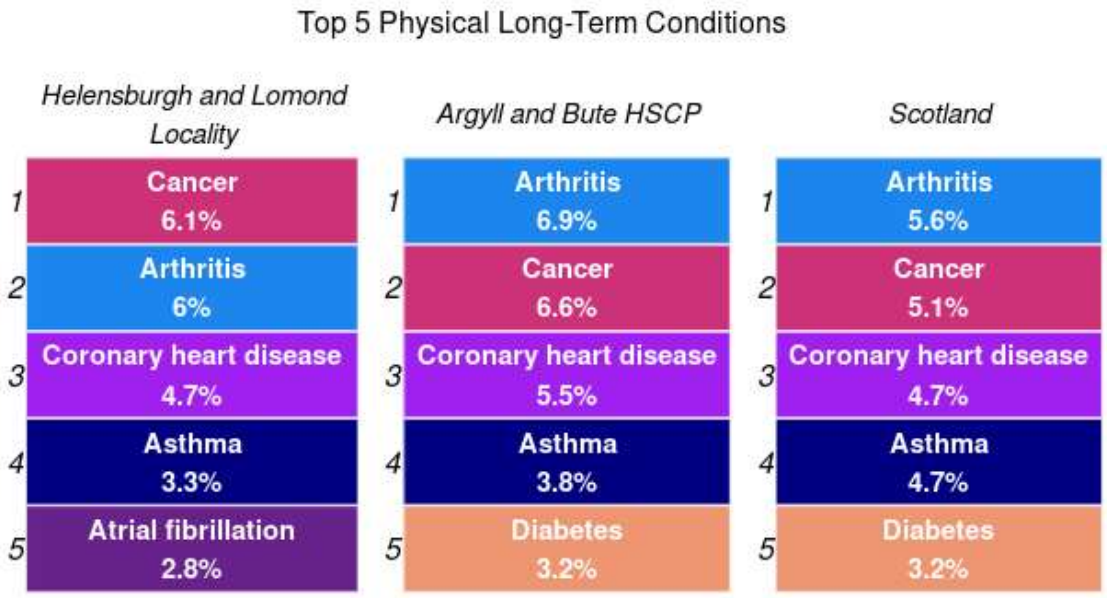
Below is a breakdown of the physical LTCs, for the financial year 2020/21. Figure 12 shows the prevalence of different LTCs in each age group in Helensburgh and Lomond locality, and Table 6 illustrates the top 5 physical LTCs across all ages at locality, partnership, and Scotland level.

Figure 12: Percentage people with each physical LTC, split by age group.



**COPD: Chronic Obstructive Pulmonary Disease*

Table 6: Prevalence of the five most common physical LTCs as a percentage of the population across geographical areas (where 1 = most prevalent).



Cancer Registrations

For the period 2017-2019, there were 177 new cancer registrations per year on average (**627** registrations per 100,000 age-sex standardised population) in Helensburgh and Lomond locality. This is a **1.9%** decrease in cancer registrations rate from the previous aggregate period 2016-2018. Figure 13 shows changes over time since 2014-2016, and Figure 14 compares the rates of localities in Argyll and Bute HSCP for the two latest available time periods.

Figure 13: Cancer registration rate over time and by geographical area.

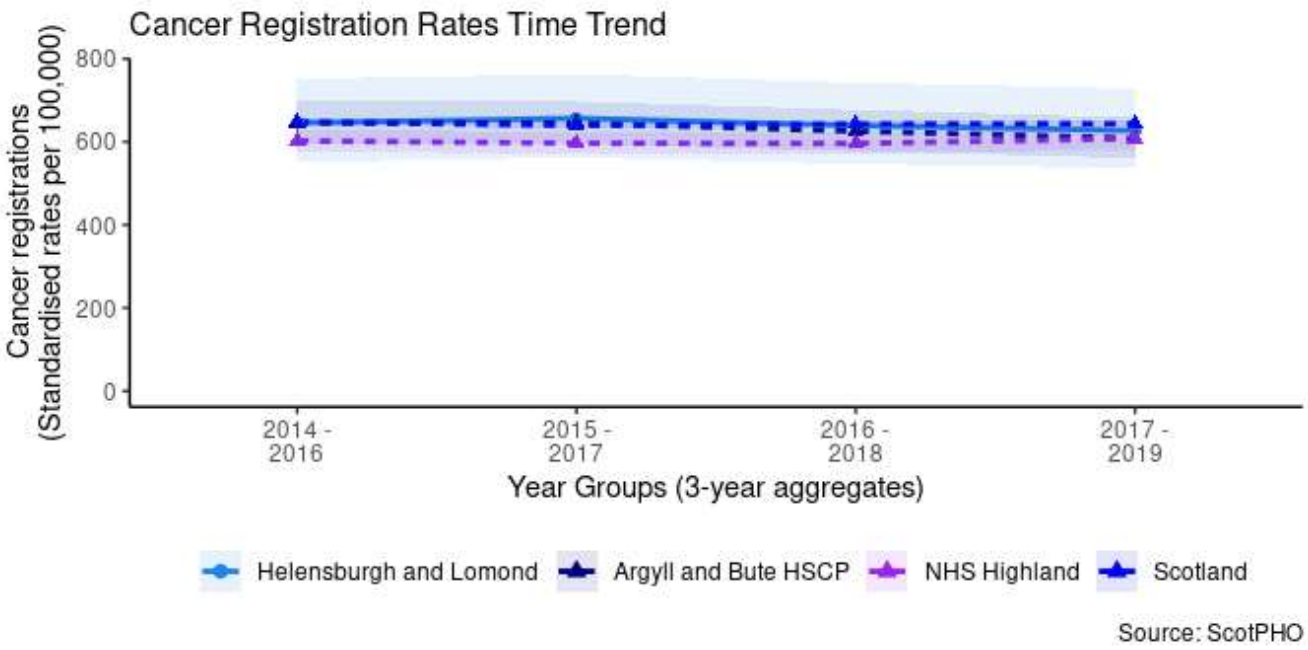
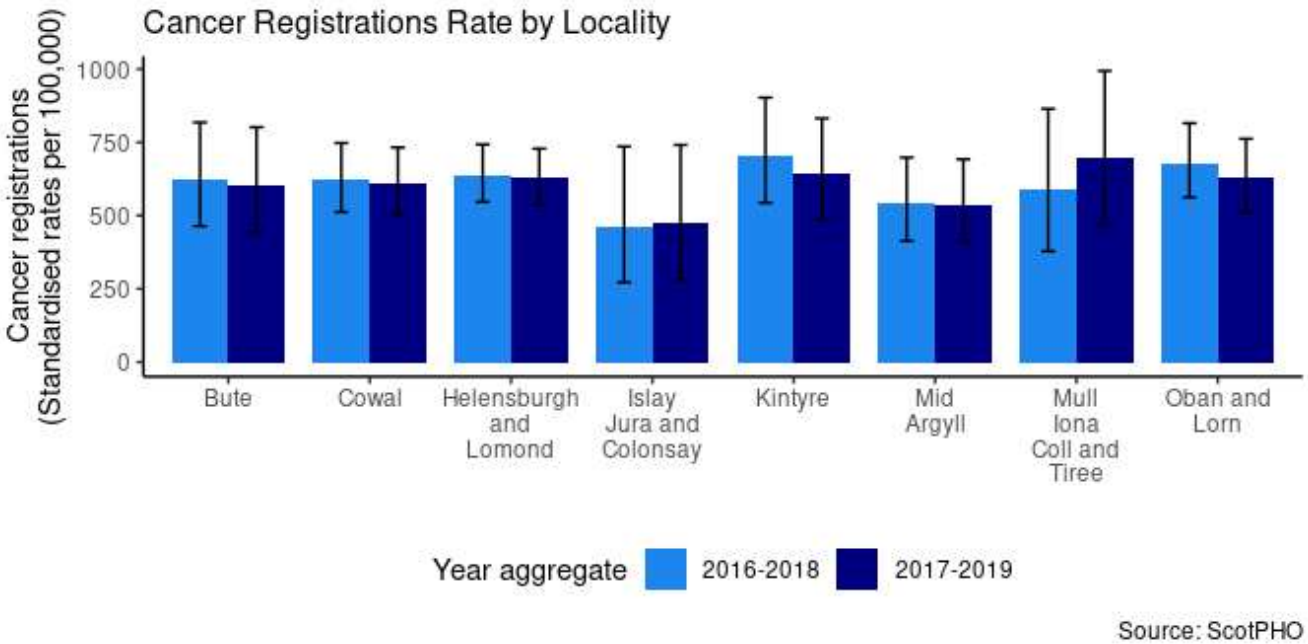


Figure 14: Cancer registration rates in Argyll and Bute HSCP localities.



Anxiety, Depression, and Psychosis Prescriptions

In the 2019/20 financial year, 16.29% of people were prescribed medication for anxiety, depression, or psychosis (ADP) in Helensburgh and Lomond Locality. This is a 0.31% decrease from the previous financial year. Differences over time and between areas may relate to multiple factors, only one of which is underlying disease. Note that data are based on main original licensed use for the prescriptions and some drugs included may be prescribed for other purposes.

Figure 15: Percentage population prescribed ADP medication in Argyll and Bute HSCP localities.

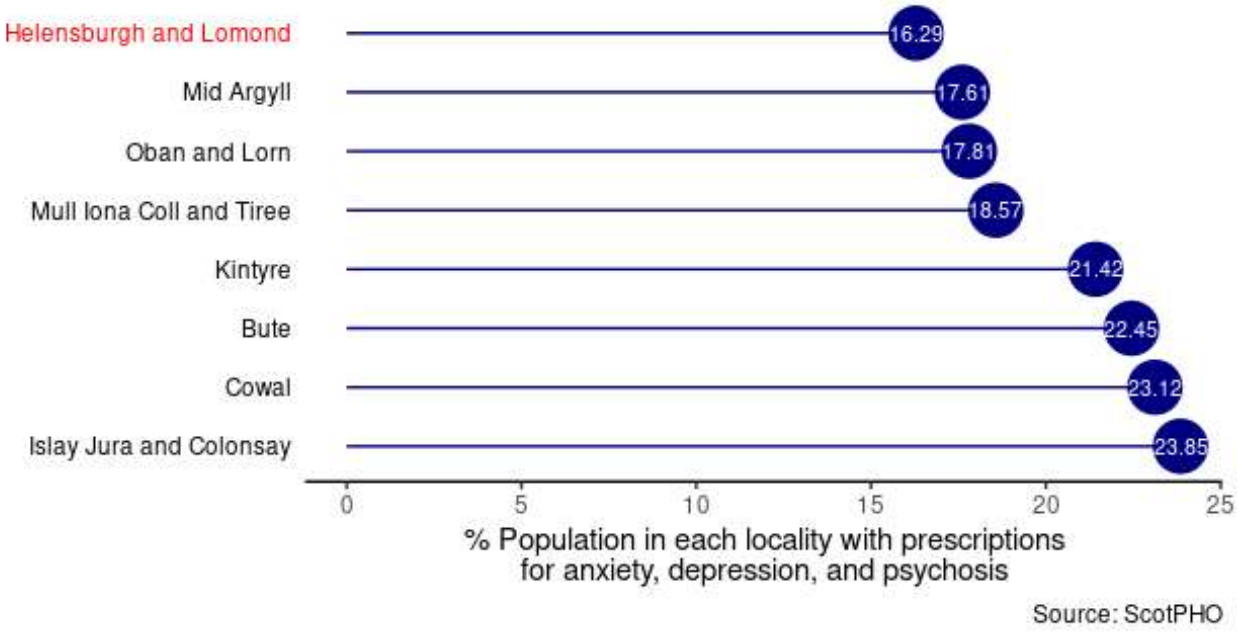
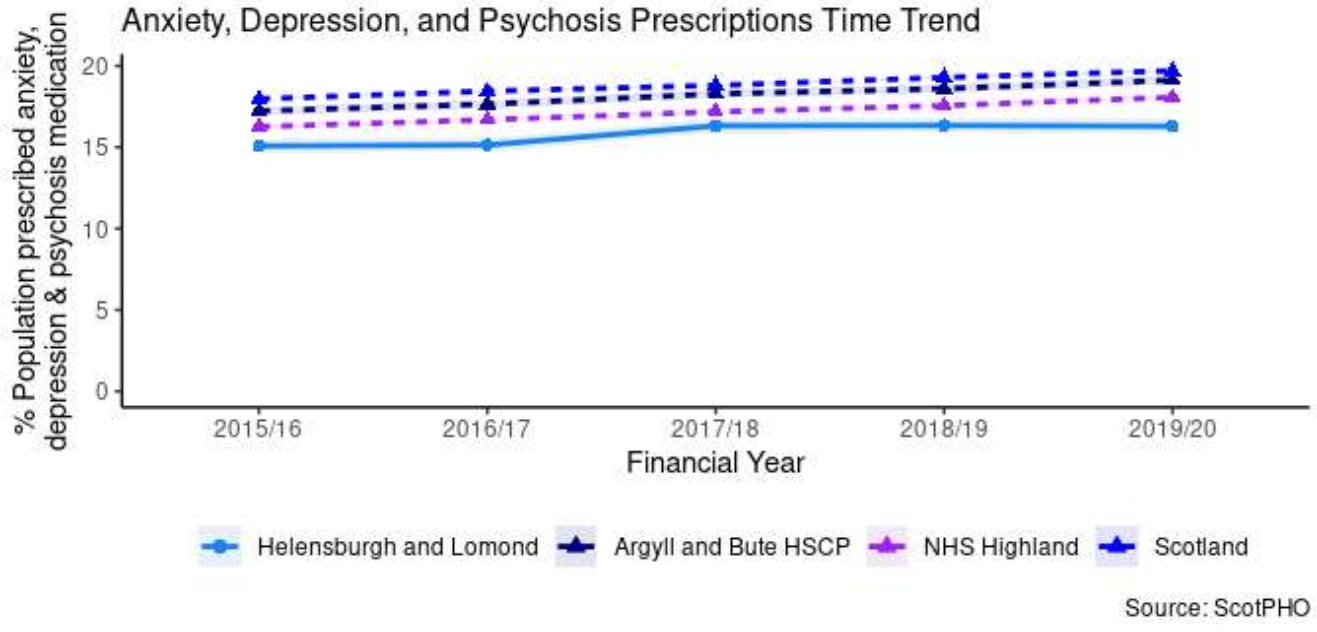


Figure 16: ADP prescriptions over time and by geographical area.



Behavioural Factors

Summary:

Mental and physical wellbeing has close ties with people's behaviours. Life circumstances including financial security, employment and location are interlinked with behavioural factors. This section provides data on drug-related hospital admissions, alcohol-related hospital admissions, alcohol-specific mortalities and bowel screening uptake, to give an overview of some behaviours known to be associated with health and wellbeing outcomes.

For the most recent time periods available[3], Helensburgh and Lomond had:

- **130** drug-related hospital admissions per 100,000 age-sex standardised population[4]. This is a lower rate of admissions than for Scotland (221).
- **536** alcohol-related hospital admissions per 100,000 age-sex standardised population[4].
- **18** alcohol-specific mortalities per 100,000 age-sex standardised population[4].
- a **65%** uptake of bowel cancer screening for the eligible population.

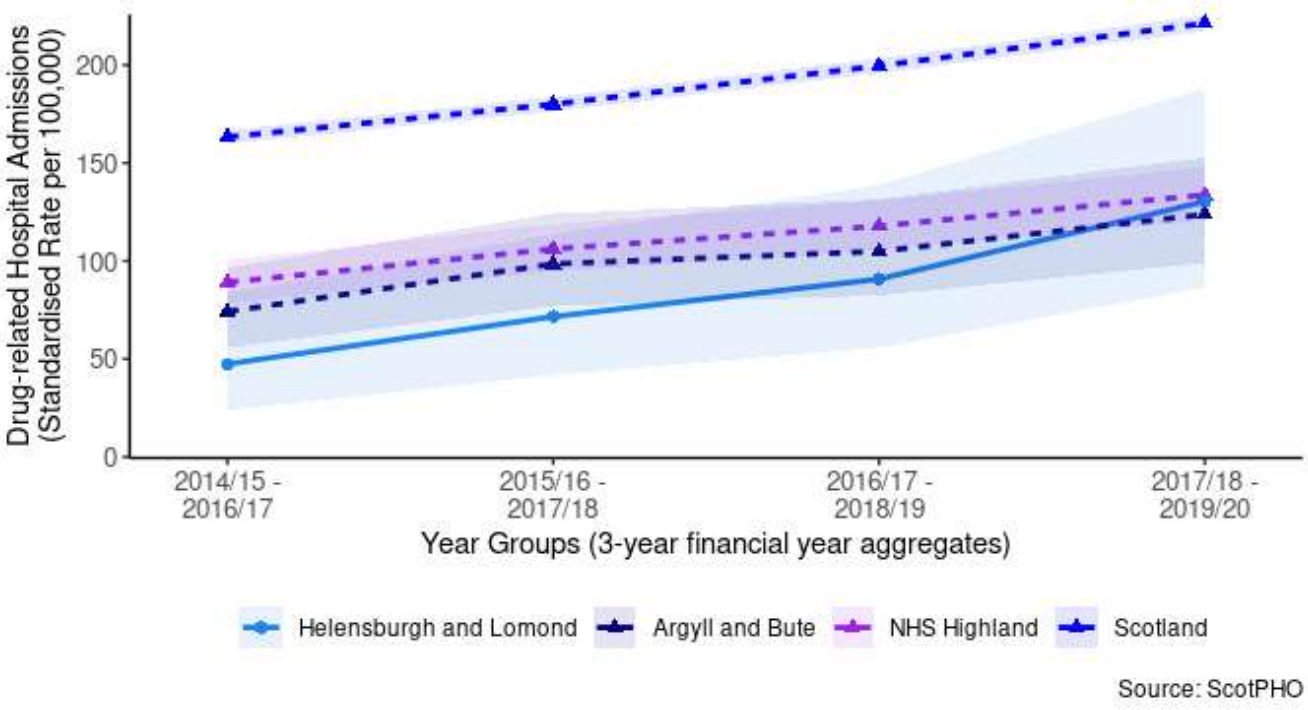
Drug-related Hospital Admissions

There were 130 drug-related hospital admissions per 100,000 age-sex standardised population[4] in Helensburgh and Lomond locality for the most recent time period available (3 year financial year aggregate for 2017/18 - 2019/20).

This is a 177% increase since 2014/15 - 2016/17 (3 financial year aggregates).

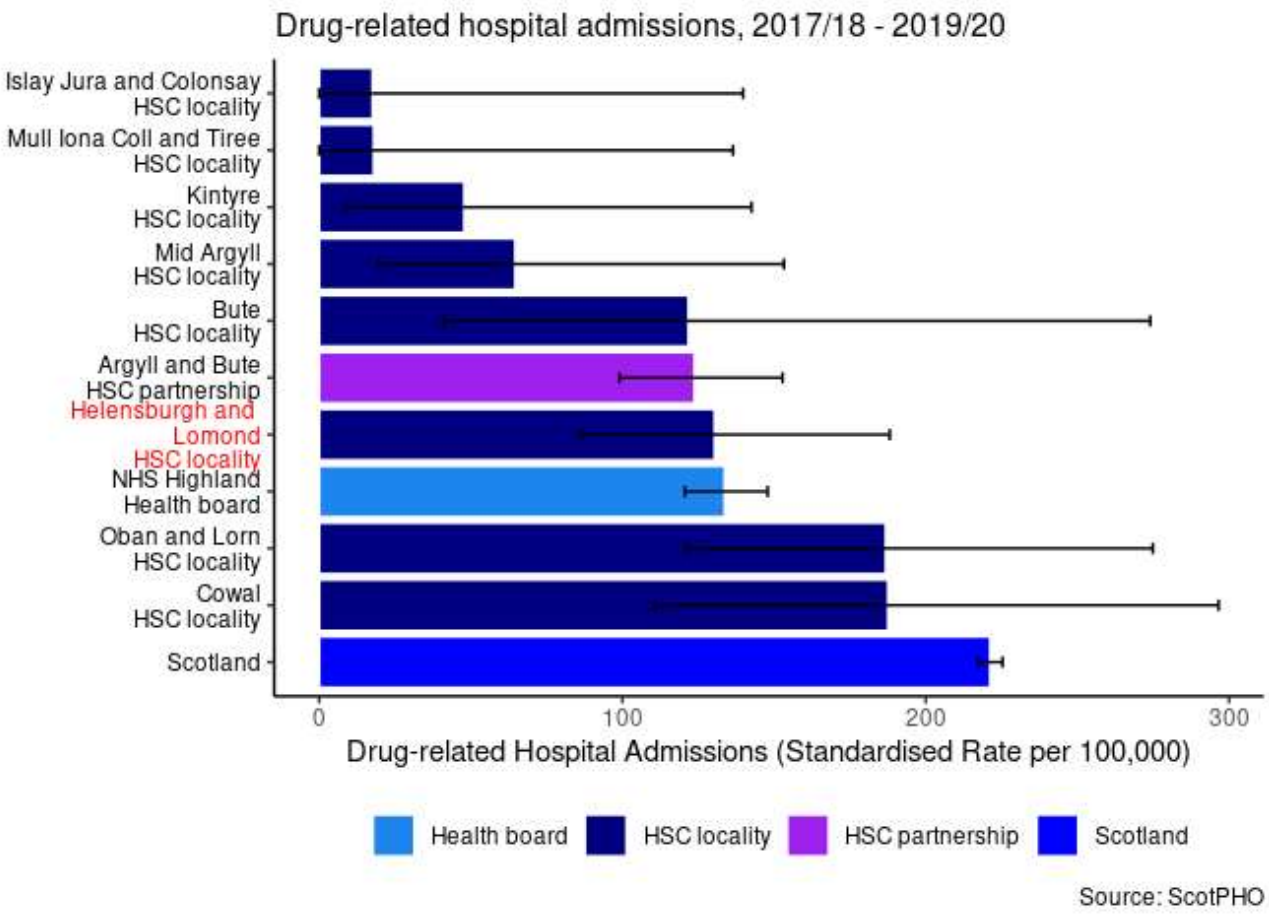
A trend of the change in drug-related hospital admissions for Helensburgh and Lomond locality compared with Scotland, Argyll and Bute HSCP and NHS Highland is shown in the chart below from 2014/15 - 2016/17 onwards.

Figure 17: Trend of Drug-related Hospital Admission Rates by geographical area.



A comparison of areas at the most recent time period (2017/18 - 2019/20 aggregated financial years) is available below. This shows Helensburgh and Lomond locality has a higher rate of admissions (130) than Argyll and Bute Partnership (124), and a lower rate of admissions than Scotland (221) overall.

Figure 18: Comparison of Drug-related Hospital Admission Rates for the period 2017/18 - 2019/20.

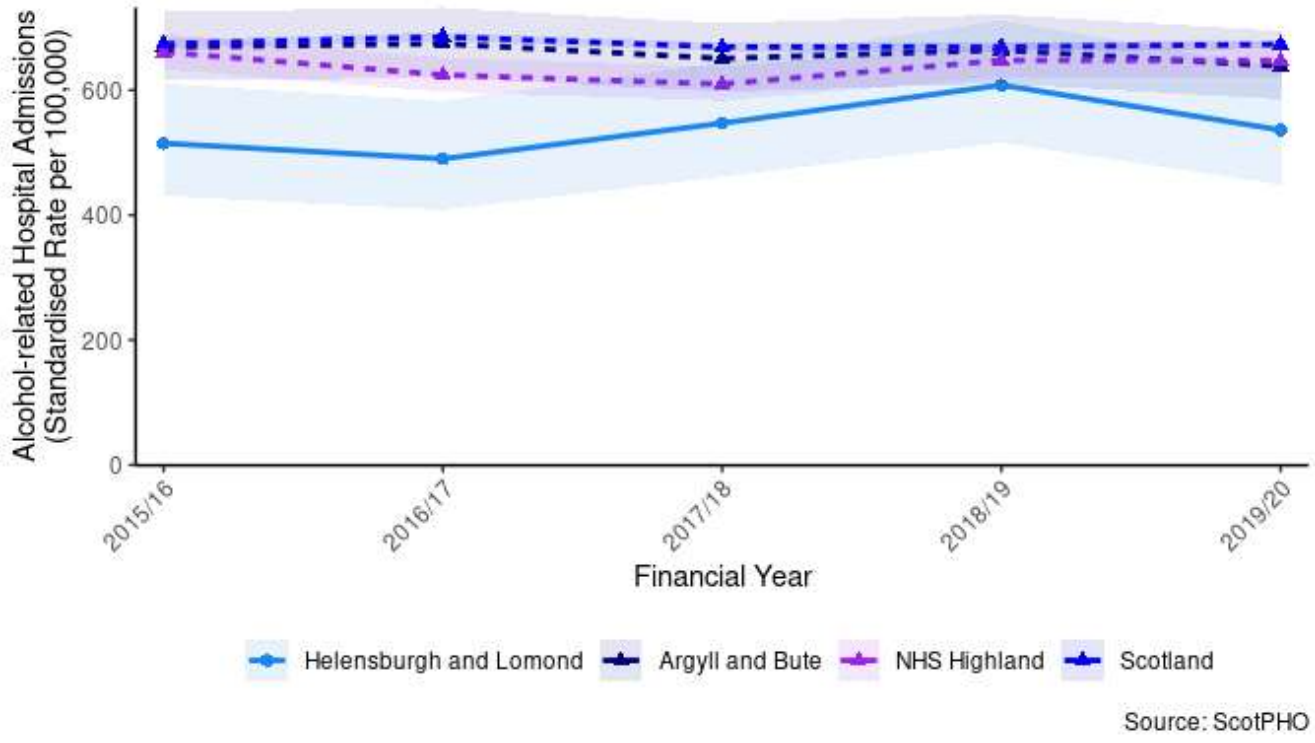


Alcohol-related Hospital Admissions

The 2019/20 alcohol-related admissions rate is 536 per 100,000 age-sex standardised population[4], which is a 4.1% increase overall since 2015/16.

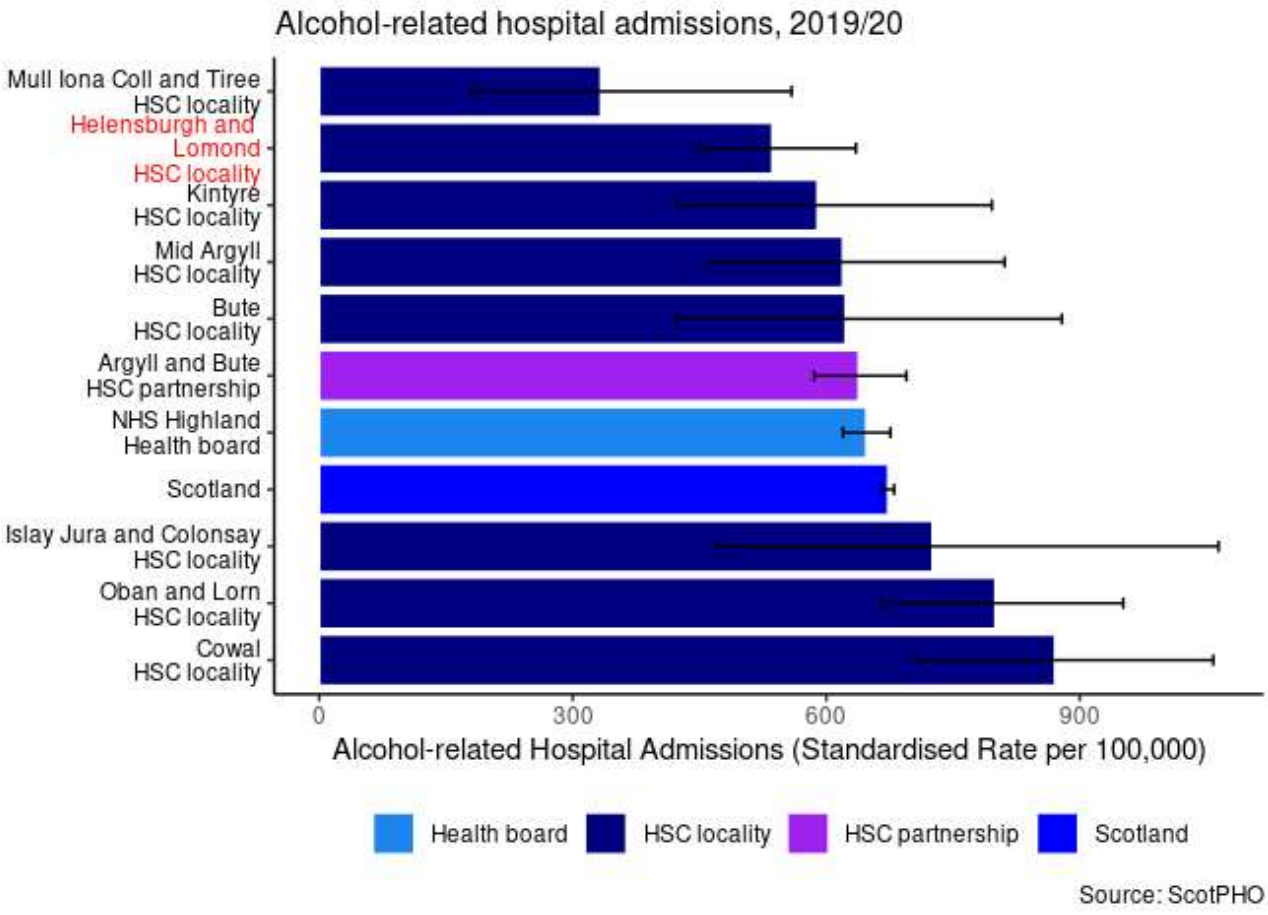
The chart below shows a trend of alcohol-related hospital admissions for Helensburgh and Lomond locality compared with Scotland, Argyll and Bute Partnership and NHS Highland from financial year 2015/16 to 2019/20.

Figure 19: Trend of Alcohol-related Hospital Admission Rates by geographical area.



Comparison across different areas for 2019/20 is shown in Figure 20. This shows that Helensburgh and Lomond locality had a lower alcohol-related hospital admissions rate (536) compared to Scotland (673).

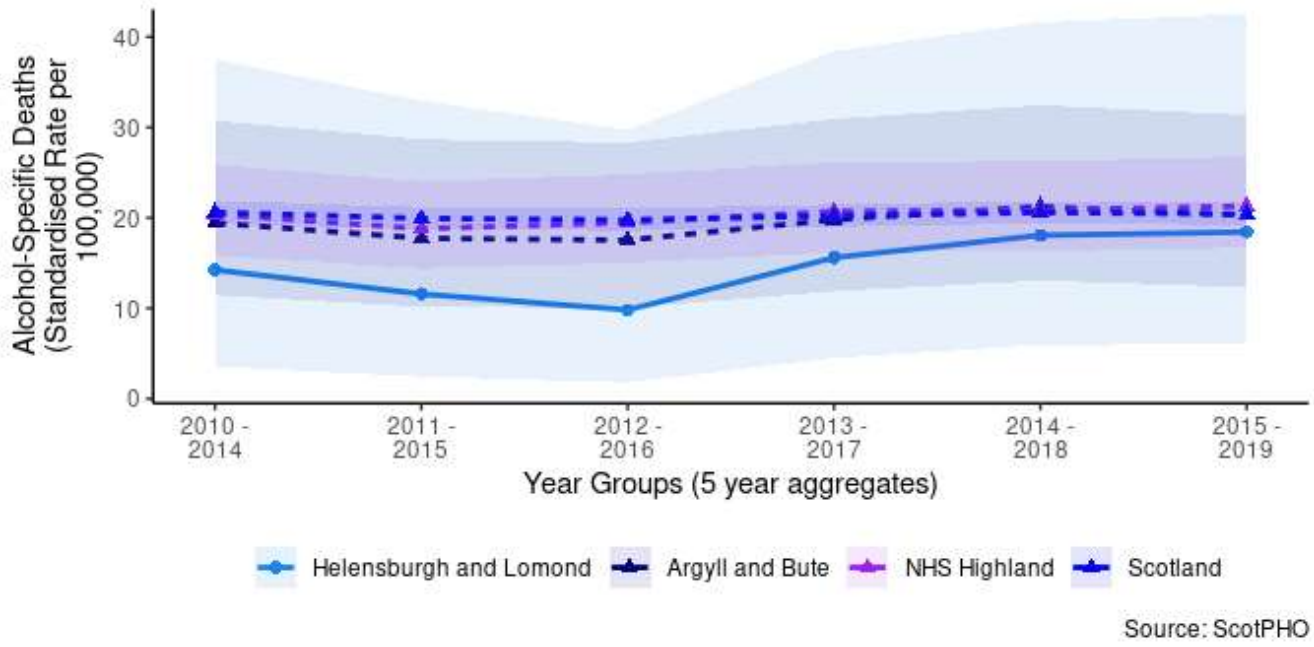
Figure 20: Comparison of Alcohol-related Hospital Admission Rates for 2019/20.



Alcohol-Specific Deaths

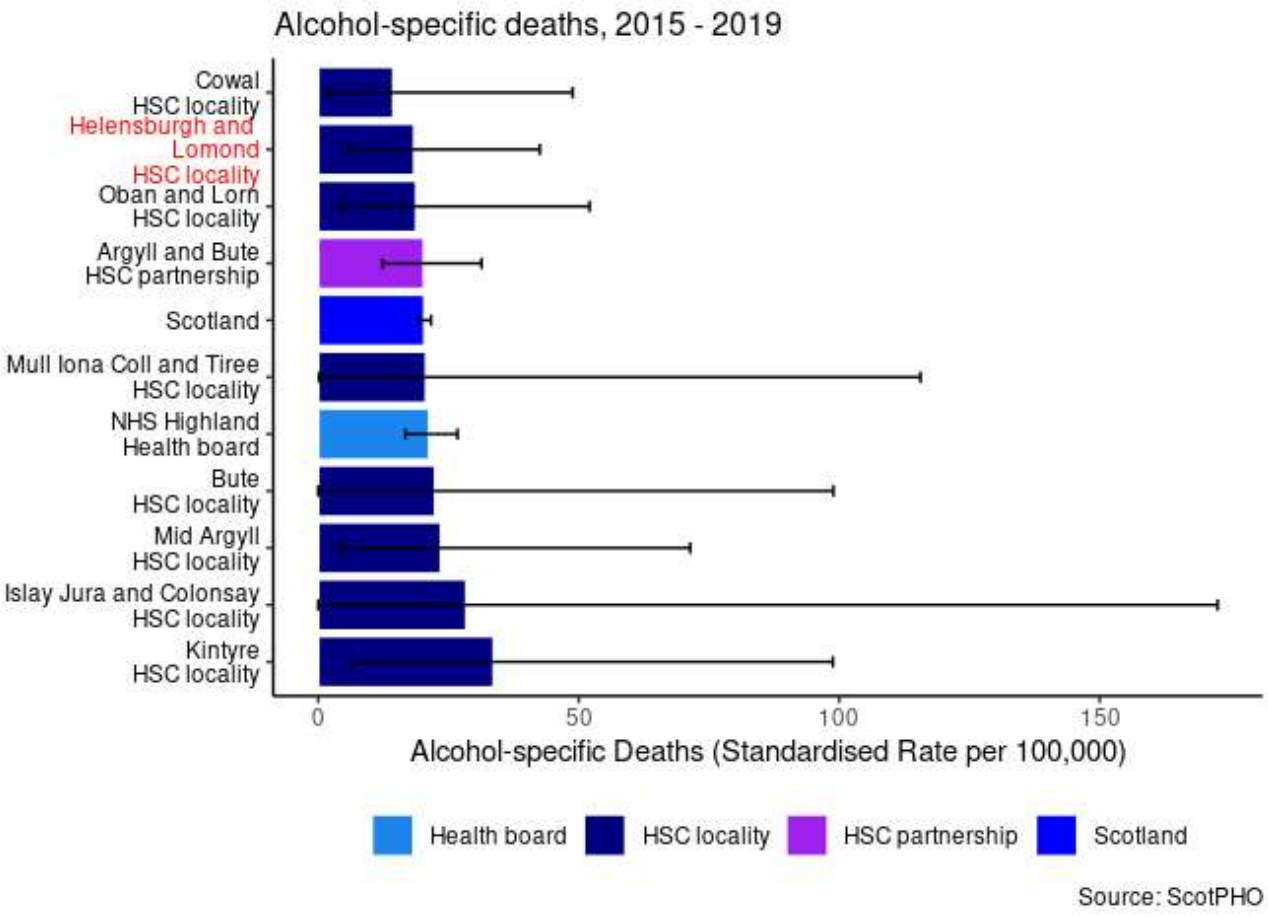
Data on alcohol-specific deaths is available as 5 year aggregates. The rate of alcohol-specific deaths is currently higher in Helensburgh and Lomond than the rate in 2010 - 2014 (30% change).

Figure 21: Trend of Alcohol-Specific Death Rates by geographical area.



A comparison across different areas illustrates that Helensburgh and Lomond locality has a lower alcohol-specific death rate compared to Scotland as a whole.

Figure 22: Comparison of Alcohol-related Death Rates for the period 2015 - 2019 (5 year aggregate).

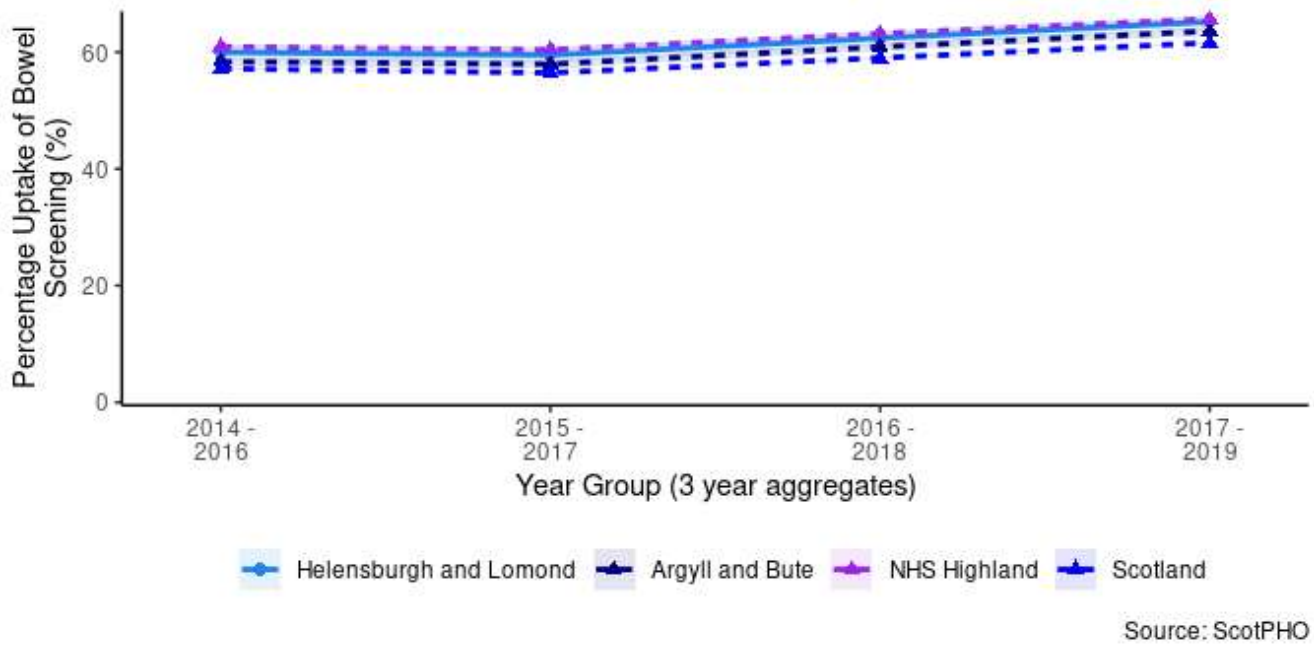


Bowel Screening Uptake

Bowel screening is offered every two years to eligible men and women aged between 50-74 years old. Eligible people are posted a test kit which is completed at home. Since 1st April 2013, those aged 75 and over can also self-refer and opt into screening.

A trend of the percentage uptake of bowel screening among the eligible population is shown below for Helensburgh and Lomond locality compared with Scotland, Argyll and Bute HSCP and NHS Highland. Data is suppressed into 3 year aggregates. The 2017 - 2019 uptake rate for Helensburgh and Lomond is **65%**.

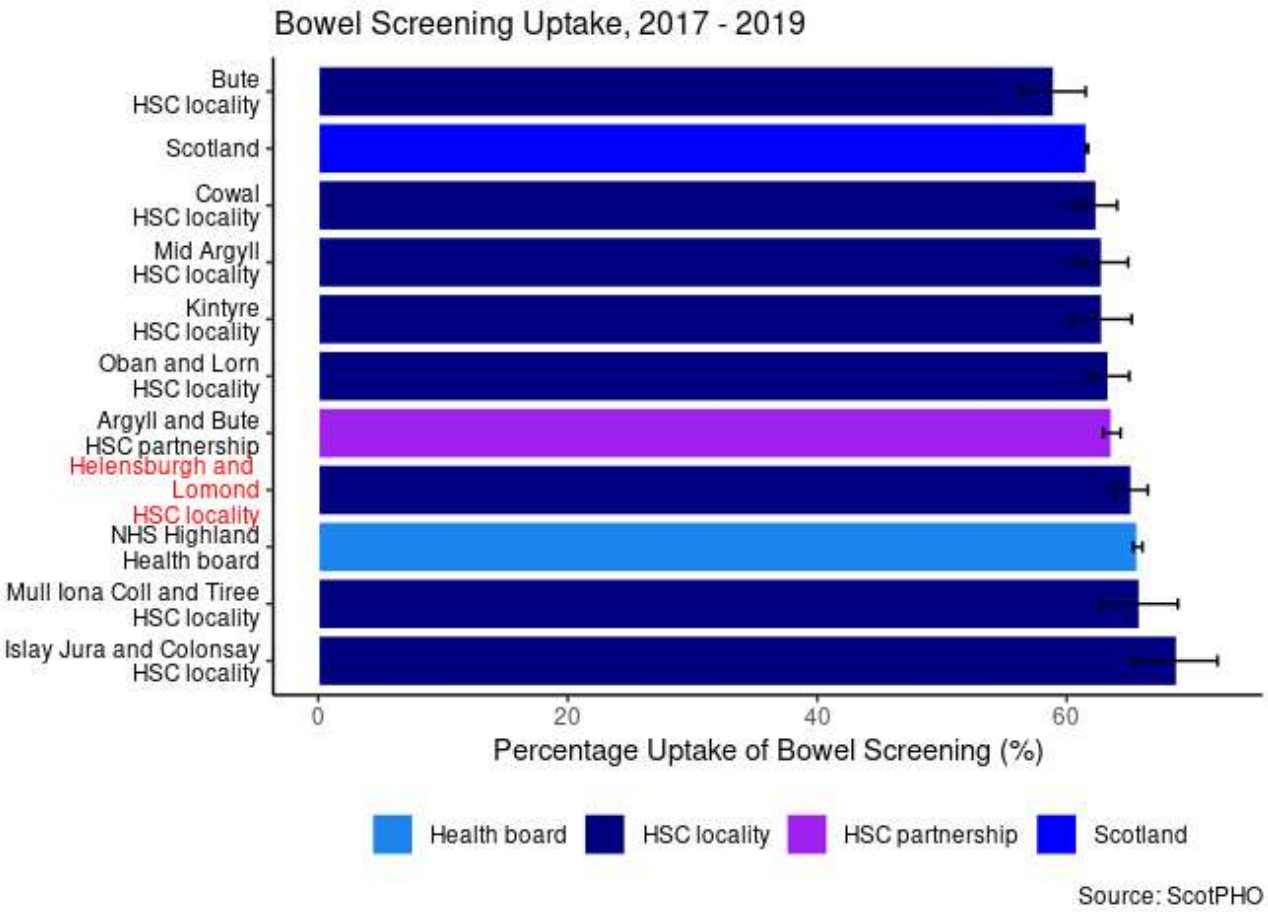
Figure 23: Trend of Bowel Screening Uptake for eligible men and women, by geographical area.



Source: ScotPHO

Compared with Scotland, Helensburgh and Lomond locality has a higher percentage uptake of bowel cancer screening for the period 2017 - 2019.

Figure 24: Comparison of Bowel Screening Uptake for 2017 - 2019.



Hospital and Community Care

This section includes acute hospital data, delayed discharge bed days and A&E attendances. Please note that for 2020 onwards, hospital activity would have been severely affected by the COVID-19 pandemic. Information on how this has had a wider impact is provided in Footnote 6 at the end of the document.

For the most recent time periods available, Helensburgh and Lomond had:

- **7,482** emergency hospital admissions per 100,000 population.
- **52,487** unscheduled acute specialty bed days per 100,000 population.
- **19,541** A&E attendances per 100,000 population.
- **5,159** delayed discharge bed days per 100,000 population.
- **568** emergency hospital admissions from falls per 100,000 population.
- **82** emergency readmissions (28 day) per 1,000 discharges.
- **863** potentially preventable hospital admissions per 100,000 population.
- People on average spent **93%** of their last 6 months of life in a community setting.

Emergency Admissions

Figure 25: Emergency admissions by age group

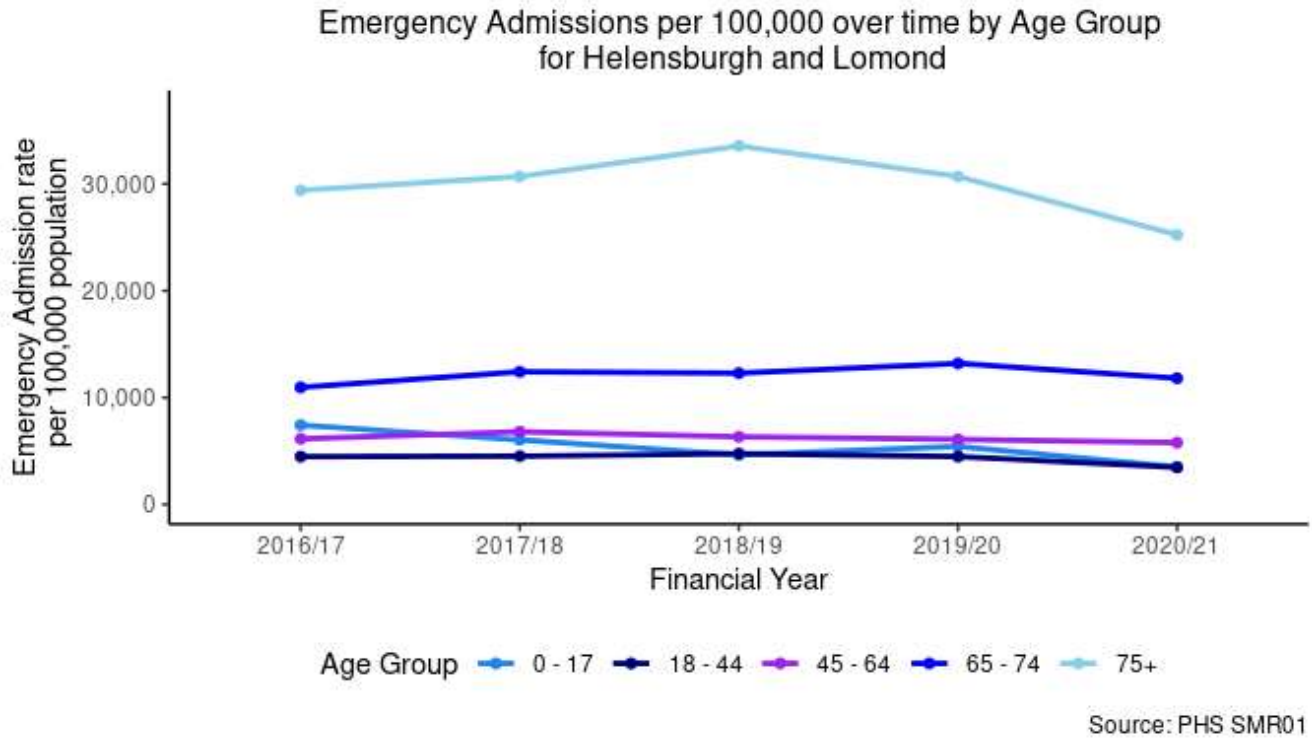
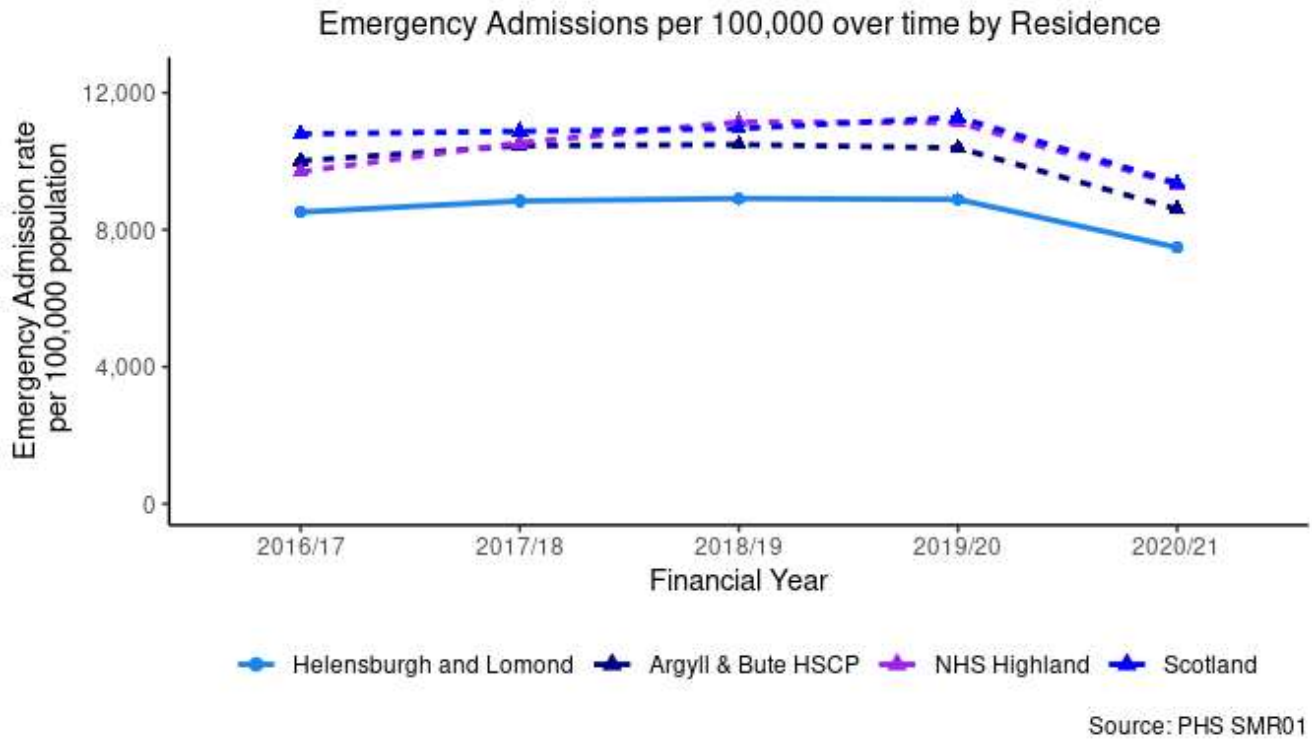


Figure 26: Emergency admissions by geographical area



Unscheduled Acute Bed Days

Figure 27: Unscheduled bed days by age group

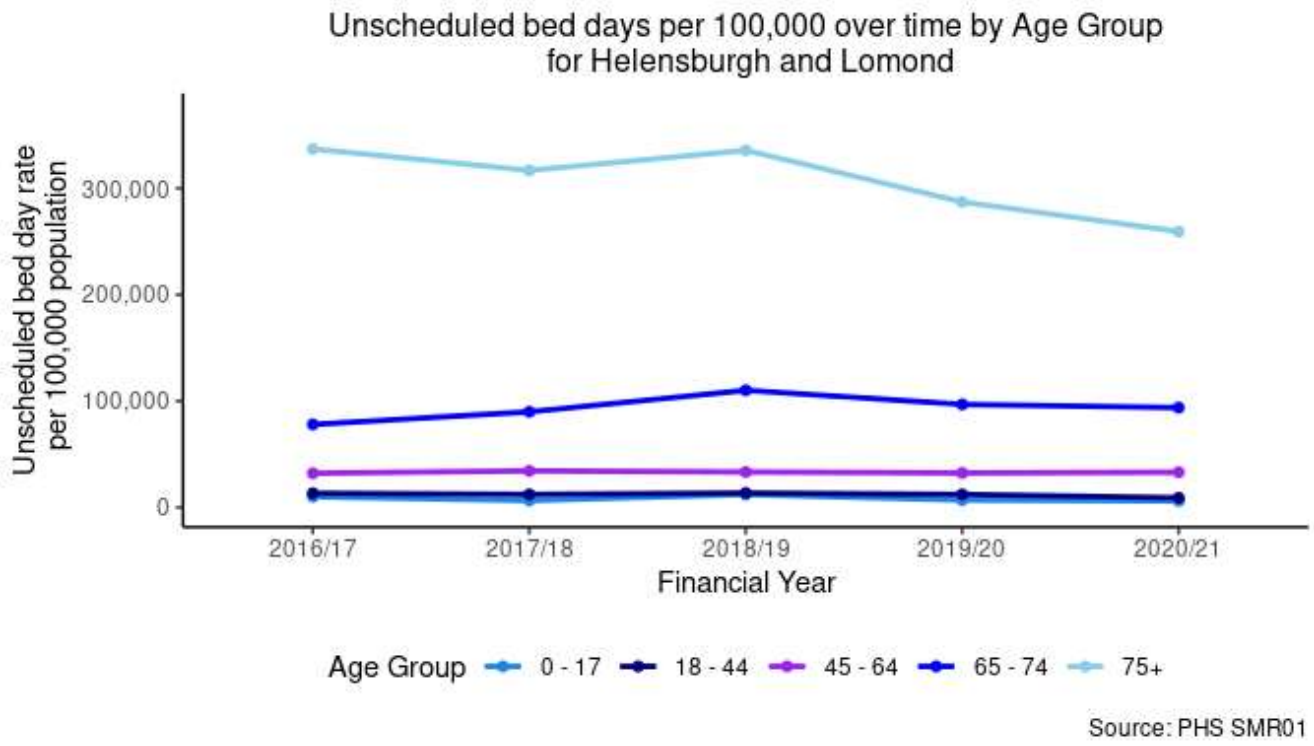
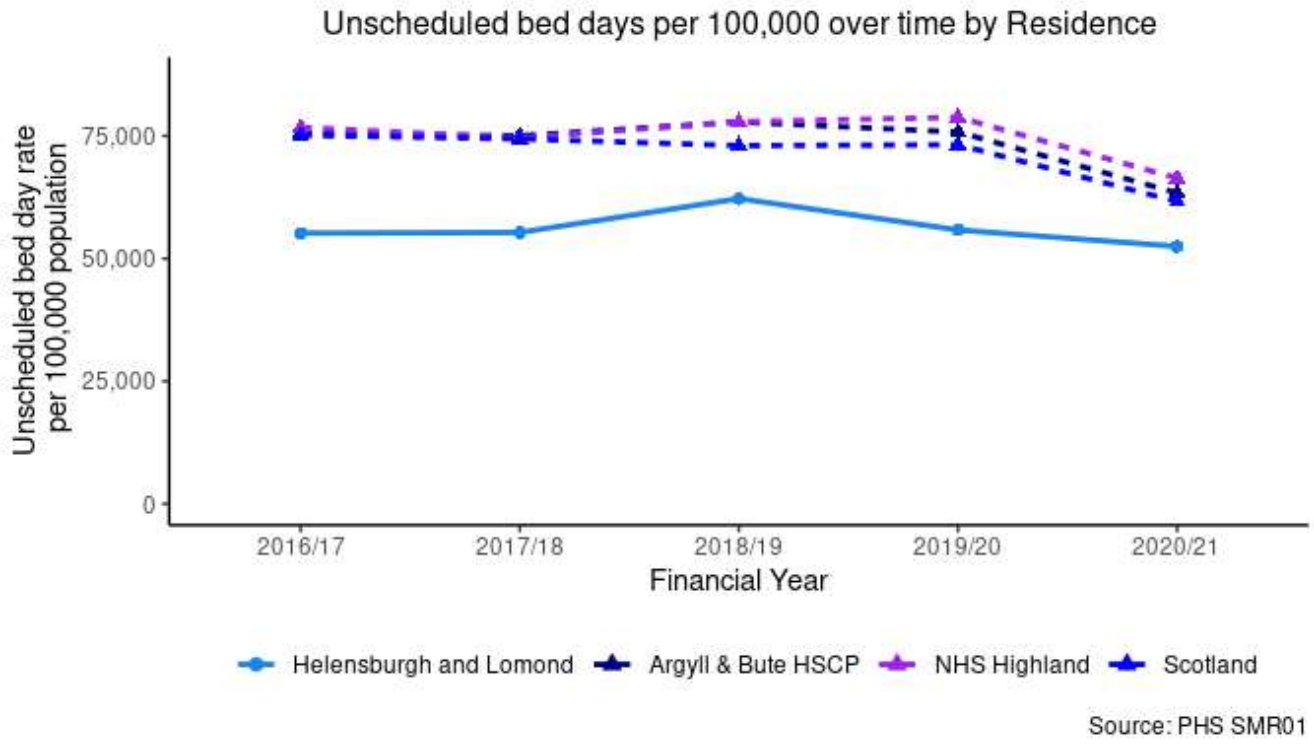


Figure 28: Unscheduled bed days by geographical area



A&E Attendances

Figure 29: A&E attendances by age group

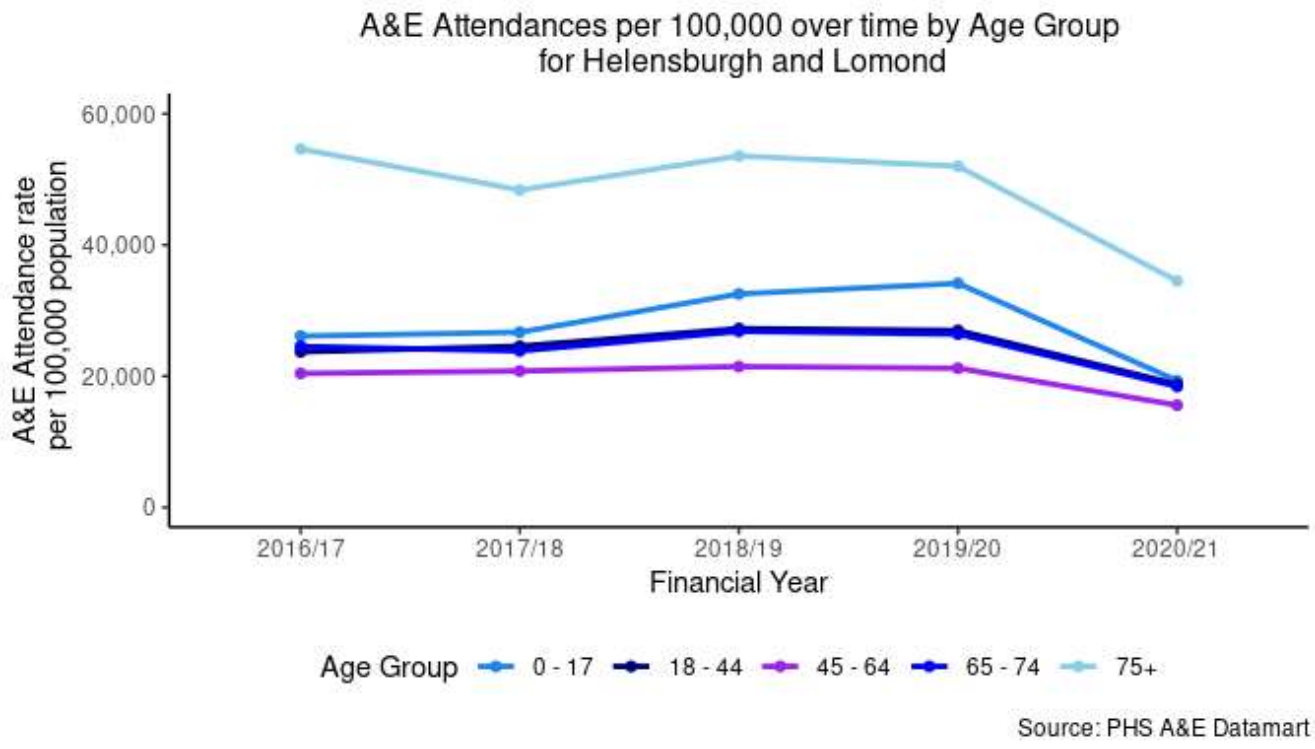
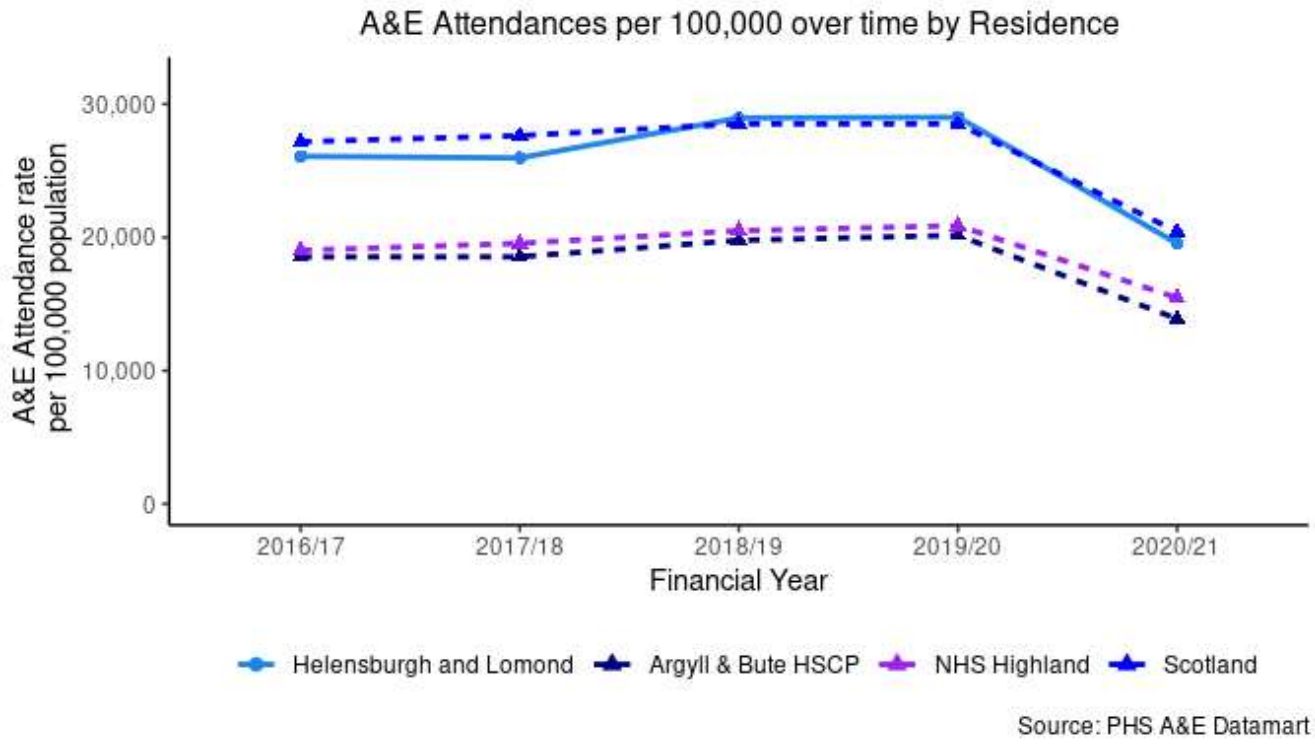


Figure 30: A&E attendances by geographical area



Delayed Discharge Bed Days

Figure 31: Delayed discharge bed days by age group

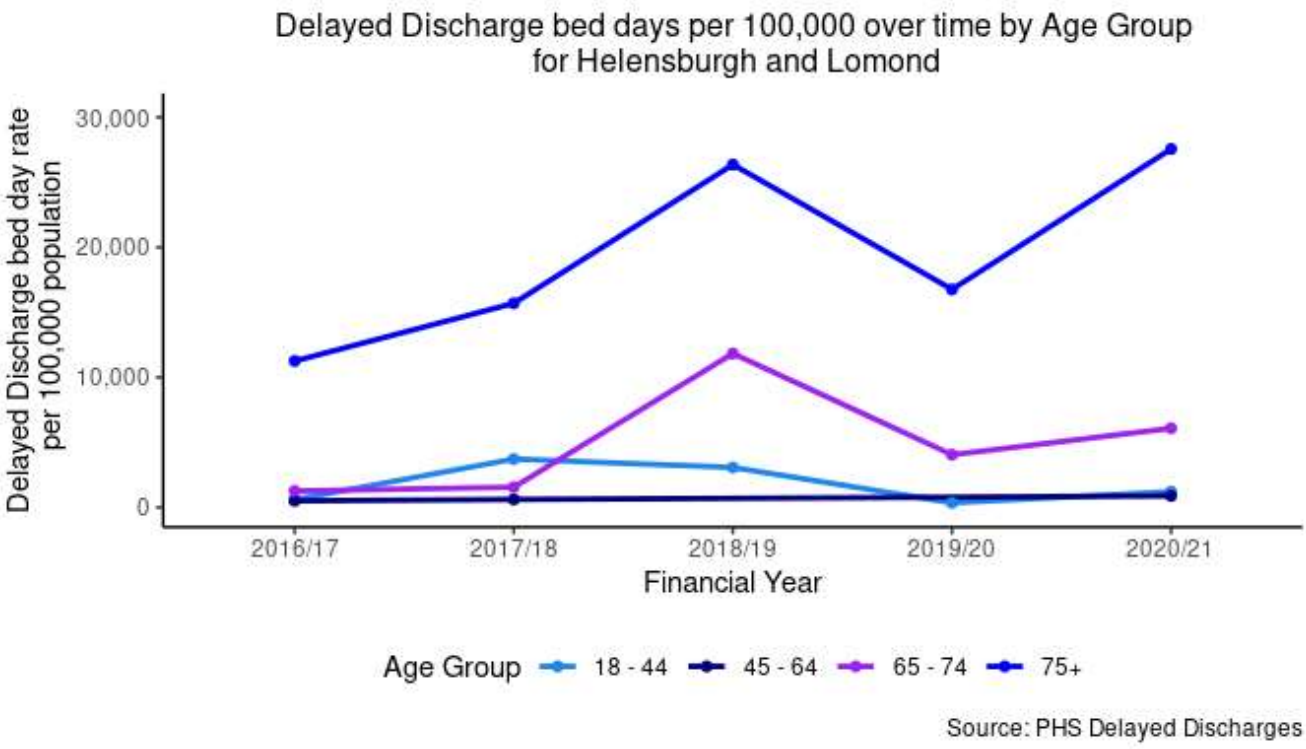
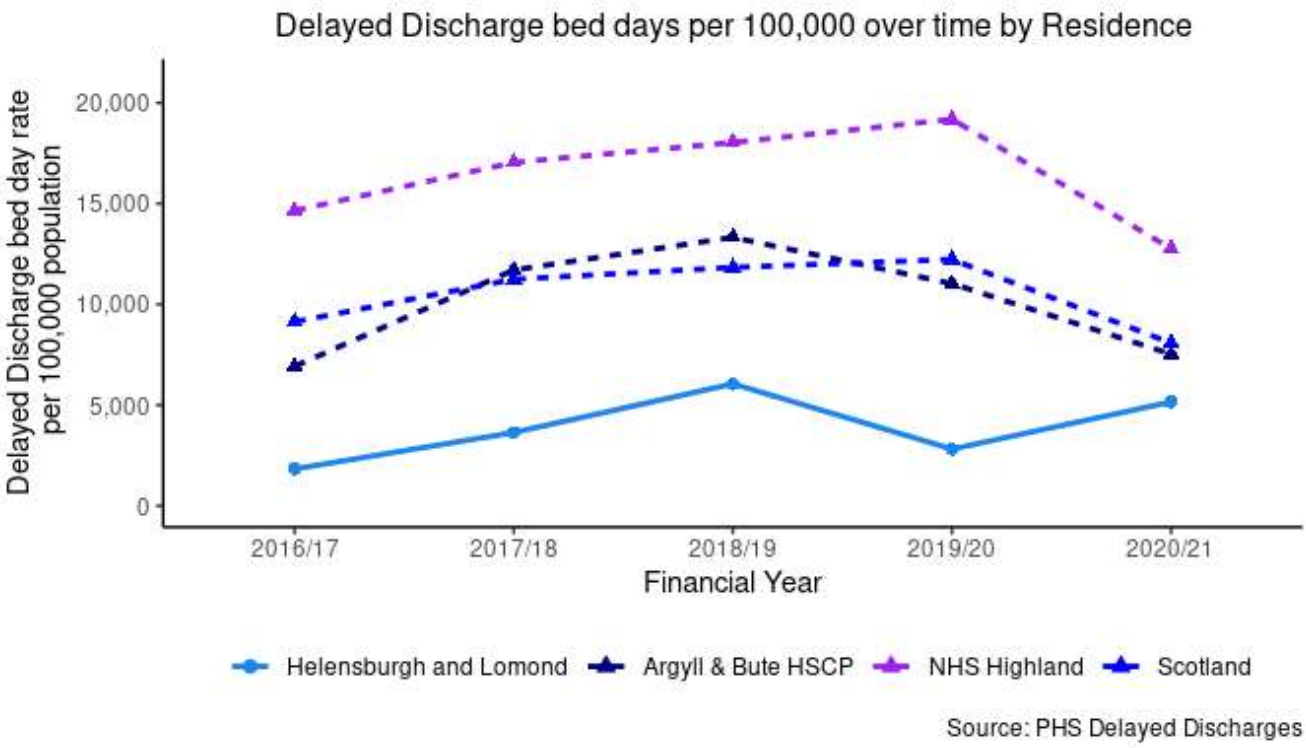
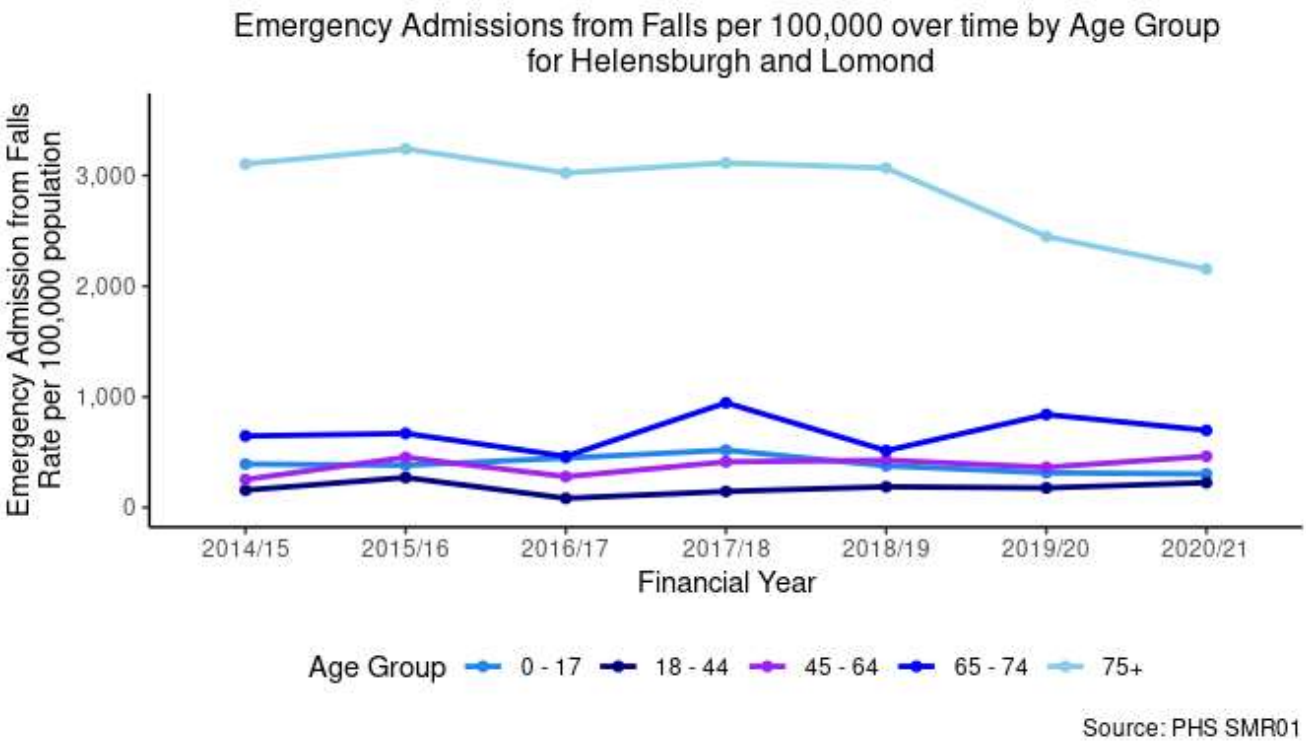


Figure 32: Delayed discharge bed days by geographical area



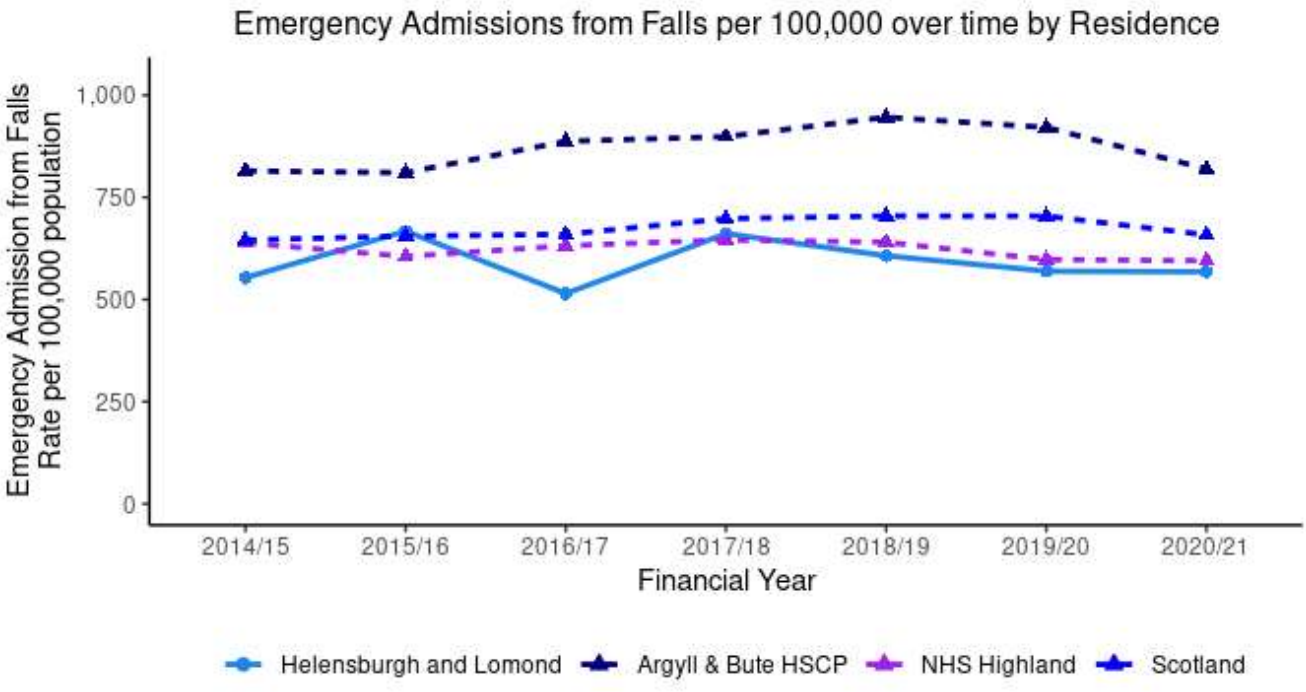
Emergency Admissions from a Fall

Figure 33: Falls by age group



Source: PHS SMR01

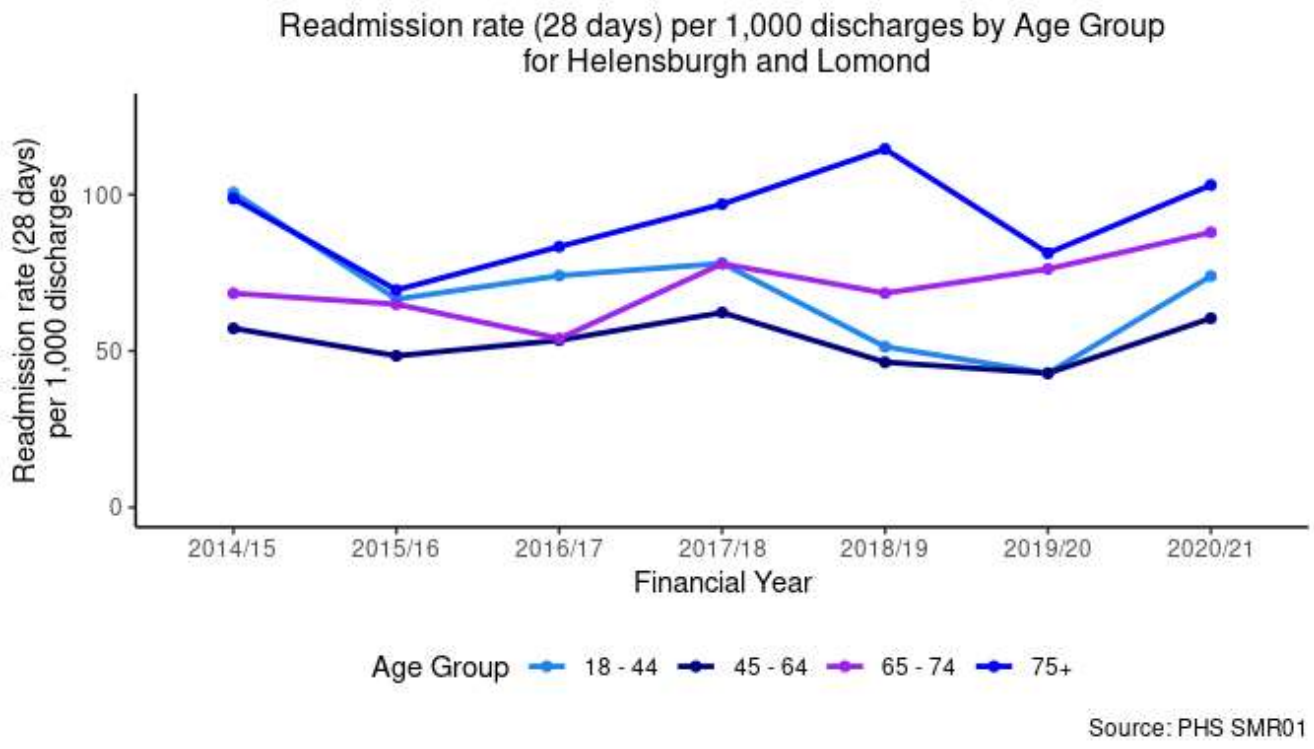
Figure 34: Falls by geographical area



Source: PHS SMR01

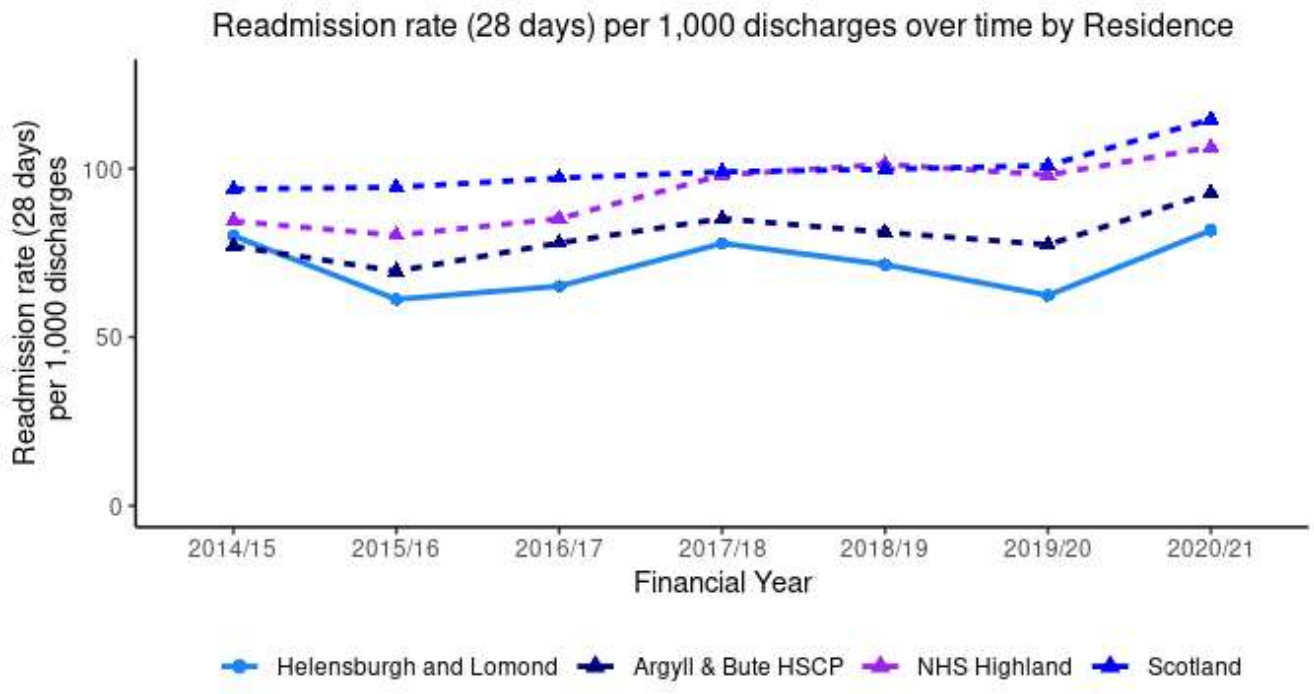
Emergency Readmissions (28 days)

Figure 35: Emergency readmissions by age group



Source: PHS SMR01

Figure 36: Emergency readmissions by geographical area

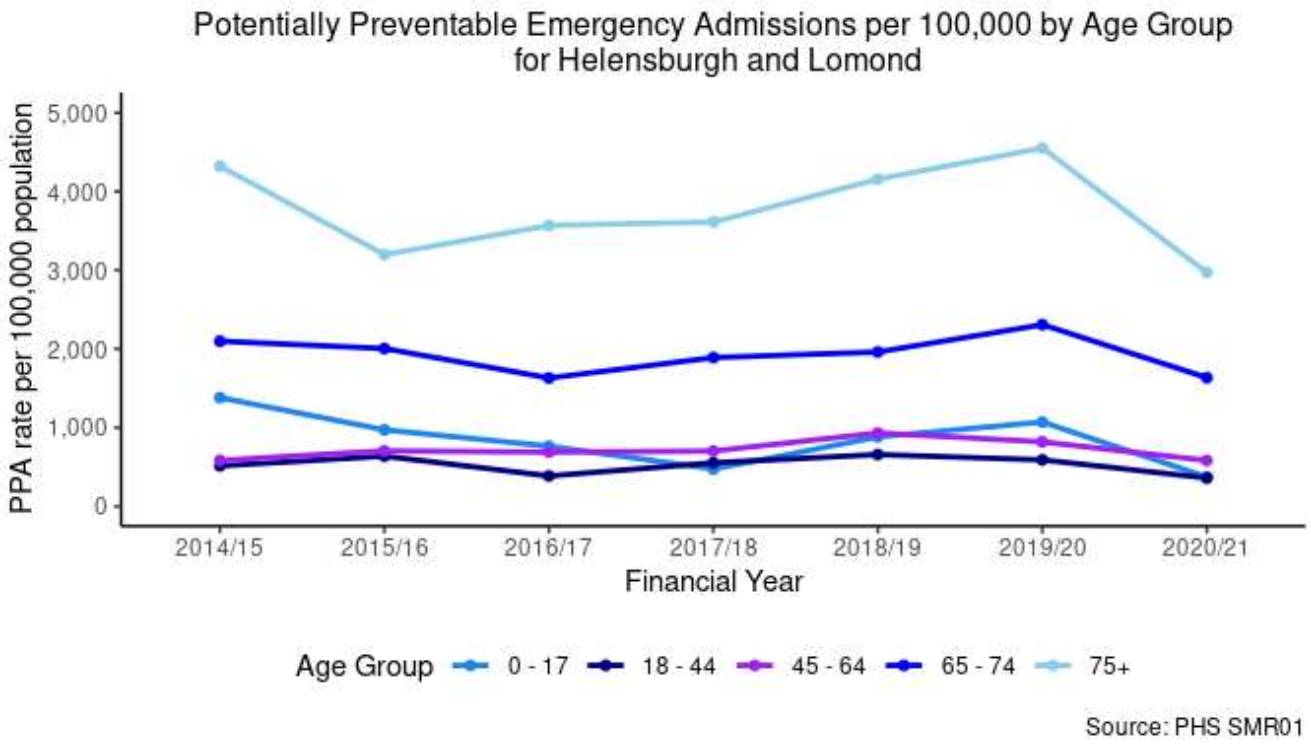


Source: PHS SMR01

Potentially Preventable Admissions (PPAs)

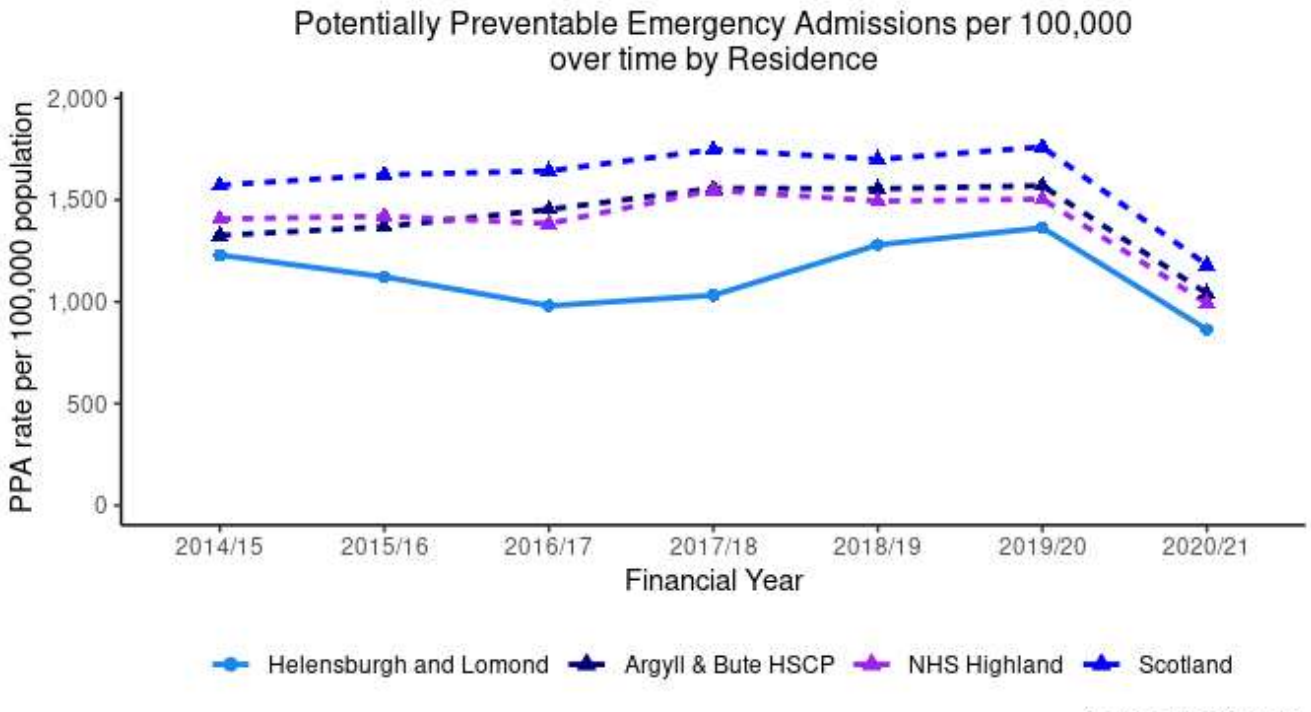
Information on which conditions are counted as PPAs is available in Appendix 3 in the accompanying summary document.

Figure 37: PPAs by age group



Source: PHS SMR01

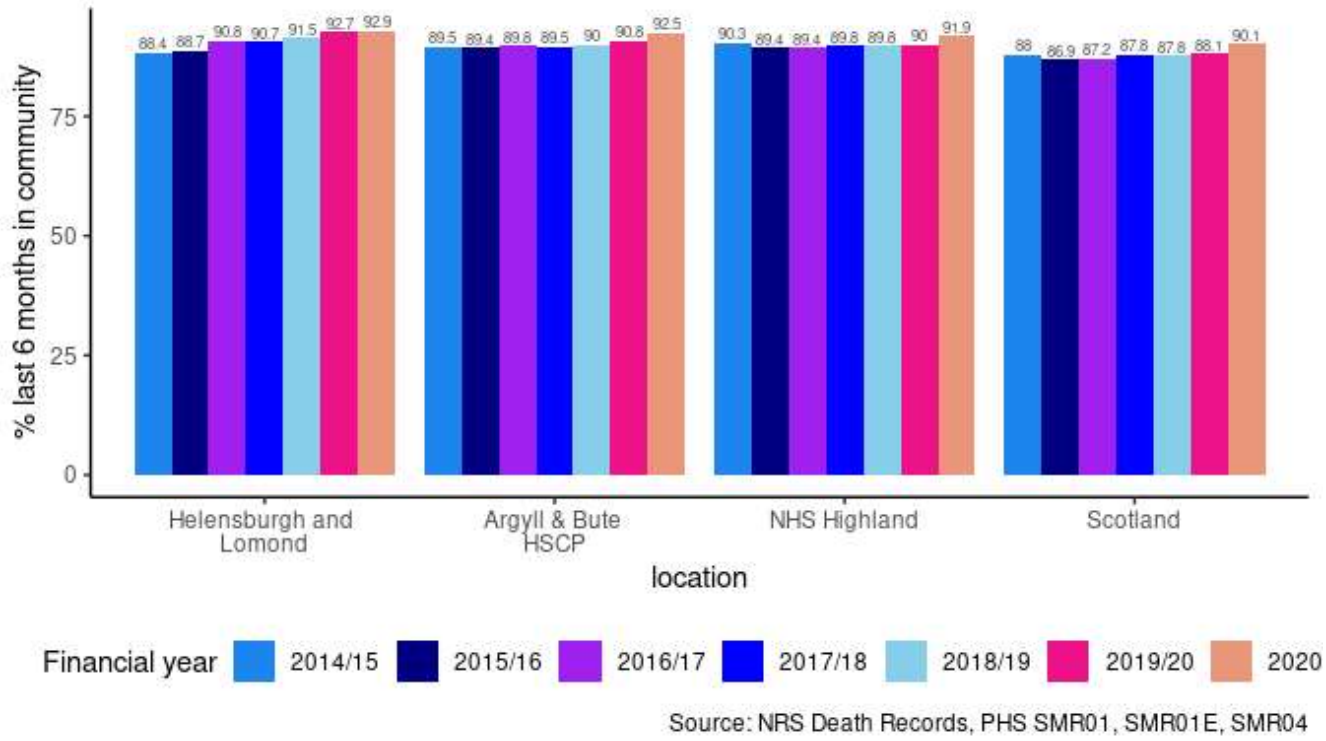
Figure 38: PPAs by geographical area



Source: PHS SMR01

% Last 6 months in a Community Setting

Figure 39: Last 6 months in a community setting by geographical area



Source: NRS Death Records, PHS SMR01, SMR01E, SMR04

Footnotes

1. Population projections are not currently provided by NRS at the locality level. To explore how the population in Helensburgh and Lomond is expected to change in the future, the percent changes in population projection to 2025 for Argyll and Bute by age group and gender were calculated from the NRS Local Authority Population Projections. These percent changes were then applied to the Helensburgh and Lomond 2018 mid-year population estimates (also split by age group and gender) to obtain population projection estimates for Helensburgh and Lomond, based on the projections for the HSCP and the current population structure of the locality.
2. Care Home Data included in the Services Map and Table was sourced from the Care Inspectorate. GP Practice data from October 2021, and Hospital and A&E data was sourced from Public Health Scotland Open Data. Only services that are within the physical boundary of the HSCP or Locality are included in the map and table, so there may be services outside Argyll and Bute which people may use but are not shown.
3. The data used in General Health and Behavioural Factors sections (except for long-term conditions) of this locality profile are taken from ScotPHO. There may be more recent data available for the indicators elsewhere.
4. Data taken from ScotPHO is often reported using the European Age-Sex Standardised Rate per 100,000. This allows for comparisons across different areas to be made. For more information on how these rates are calculated, please refer to www.isdscotland.org/Products-and-Services/GPD-Support/Population/Standard-Populations/
5. Physical long-term conditions data comes from the Source Linkage Files, and the conditions are identified using ICD-9 and ICD-10 codes in the diagnosis fields. Please note that the Source Linkage Files data only contains information on people who have had contact with the NHS through either inpatient admissions, outpatient attendances, daycase attendances, A&E attendances or through prescribed items, the data does not show all service users in Scotland who have been diagnosed with an LTC as not all of these individuals will have used these services. Also note that LTC rates are based on an adjusted population indicator in the Source Linkage Files so that population sizes are closer to the official estimates.
6. The 2020 COVID-19 pandemic will have had an effect on the most recent data available. A dashboard has been created by PHS which show the wider impacts of COVID-19 over many areas. You can access this here: https://scotland.shinyapps.io/phs-covid-wider-impact/

Locality Profile

Mid Argyll Locality

October 2021

Table of Contents

Notes for this profile:

- All years shown are calendar years unless otherwise specified.
- Upper and lower 95% confidence intervals are shown throughout this document where available. In charts, these are displayed as shaded areas either side of trend lines, or as black error bars in bar charts. Confidence intervals show the range of possible values and a certainty that the true value falls within them.
- Definitions for the indicators shown are available in Appendix 1 in the accompanying summary document.
- Any zero figures for some indicators will indicate either suppression of small data or a complete lack of data available for this locality
- Data should be interpreted with caution, particularly for areas with relatively small population sizes where indicator data is expected, by chance alone, to have higher variation than in areas of larger population size. Note that differences between areas can relate to multiple factors including, for example, underlying rates of illness, rates of diagnosis and local differences in practice e.g. in data recording.

Demographics

Summary:

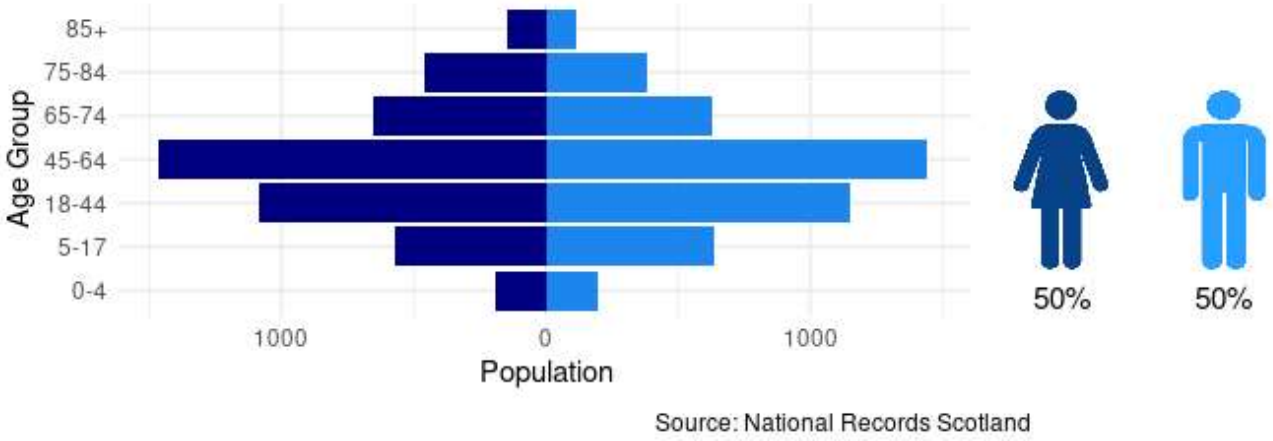
For the most recent time periods available, Mid Argyll Locality had:

- A total population of **9,118** people, where **50%** were male, and **26%** were aged over 65.
- **0%** of people lived in the least deprived SIMD quintile, and **0%** lived in the most deprived quintile.

Population

In 2020, the total population of Mid Argyll locality was 9,118. The graph below shows the population distribution of the locality.

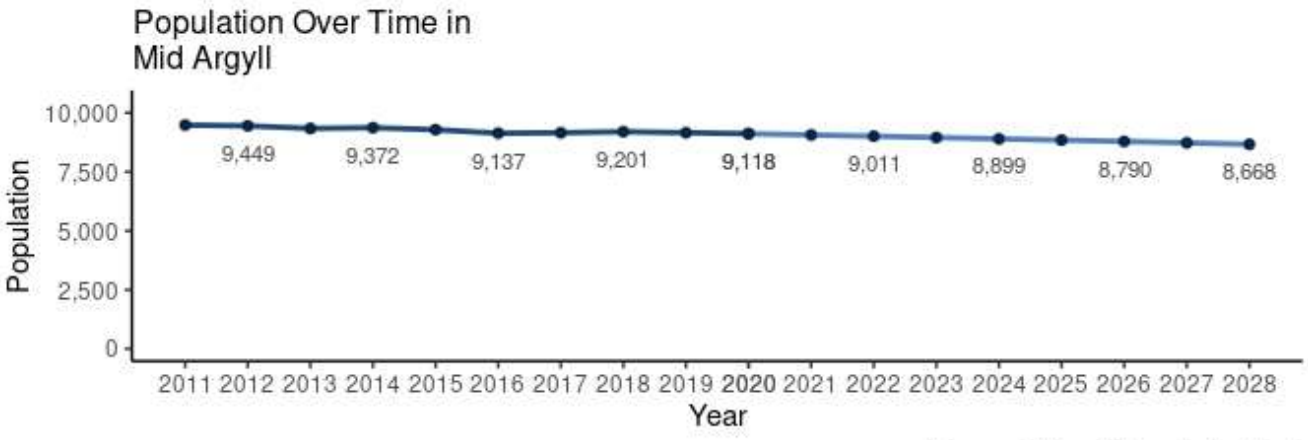
Figure 1: Population breakdown in Mid Argyll.



Source: National Records Scotland

Figure 2 shows the historical population of Mid Argyll, along with the NRS population projections. The population has been falling. The population in Mid Argyll is estimated to decrease by 3% from 2020 to 2025 *Please see the footnotes for more information on how the population projections were calculated*[1].

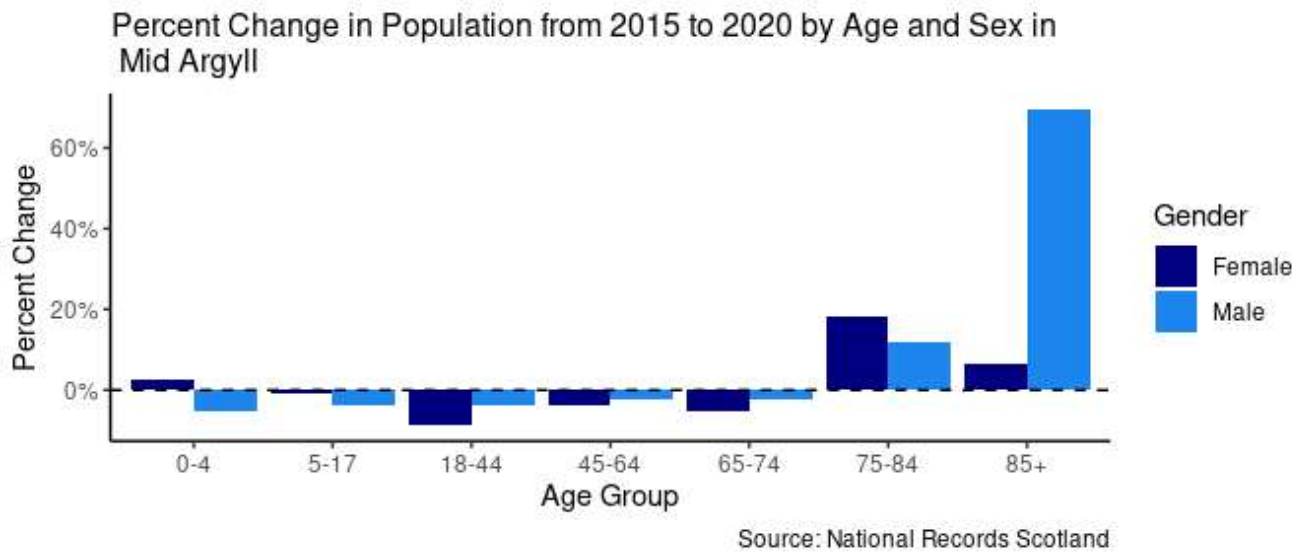
Figure 2: Population time trend and projection.



Source: National Records Scotland

Figure 3 shows how population structure has changed between 2015 and 2020.

Figure 3: Change in population structure over the last five years.



Deprivation

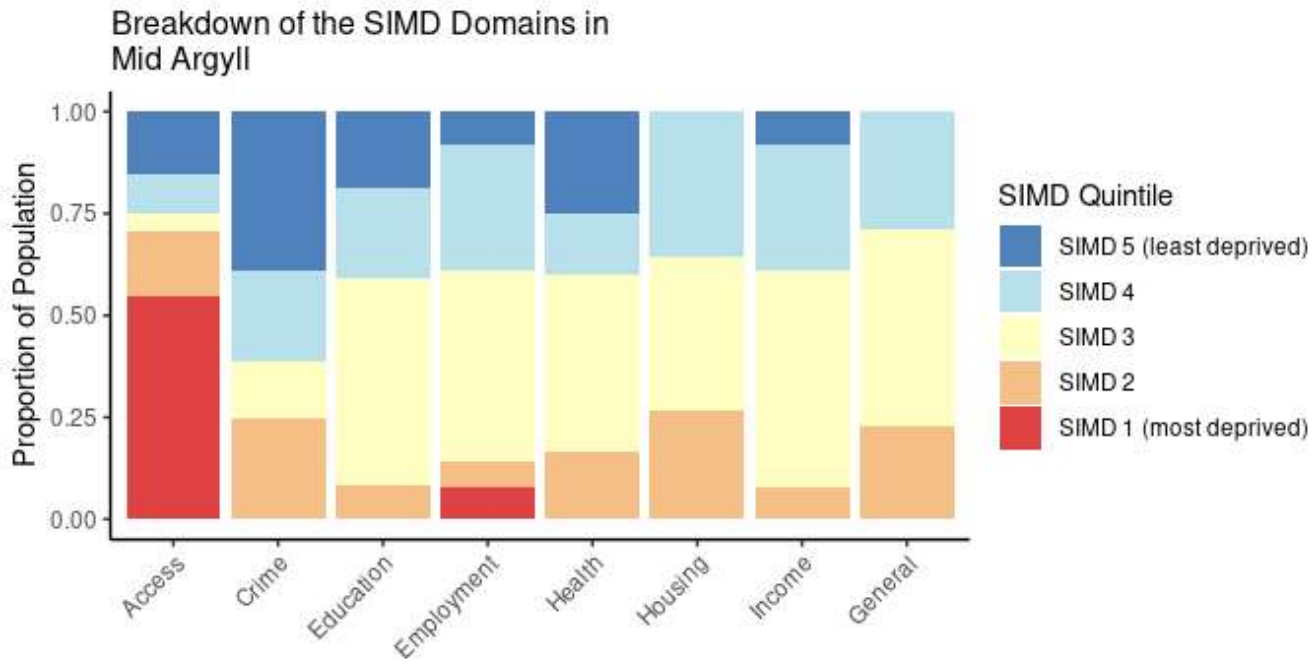
The following section explores the deprivation structure of Mid Argyll through the Scottish Index of Multiple Deprivation (SIMD). The SIMD ranks all datazones in Scotland by a number of factors; Access, Crime, Education, Employment, Health, Housing and Income. Based on these ranks, each datazone is then given an overall deprivation rank, which is used to split datazones into Deprivation Quintiles (Quintile 1 being the most deprived, and Quintile 5 the least). The most recent SIMD ranking was carried out in 2020. This section mainly focuses on the SIMD 2020 classifications, however the 2016 classifications are used to assess how deprivation has changed in Mid Argyll when compared to the rest of Scotland.

Of the 2020 population in Mid Argyll, **0%** live in the most deprived SIMD Quintile, and **0%** live in the least deprived SIMD Quintile. The following table details the percent of the population living in the 2016 SIMD Quintiles, the percent living in the 2020 SIMD Quintiles, and their difference for comparison.

Table 1: Percentage population living in the 2016 and 2020 SIMD Datazone Quintiles

Quintile	Percent of Pop (2016)	Percent of Pop (2020)	Difference
SIMD 1	0.0%	0.0%	0.0%
SIMD 2	8.4%	22.7%	14.3%
SIMD 3	58.9%	48.6%	-10.3%
SIMD 4	32.8%	28.7%	-4.0%
SIMD 5	0.0%	0.0%	0.0%

Figure 4: Proportion of the population that reside in each 2020 SIMD quintile by domain.



Source: Scottish Government, Public Health Scotland, National Records Scotland

Households

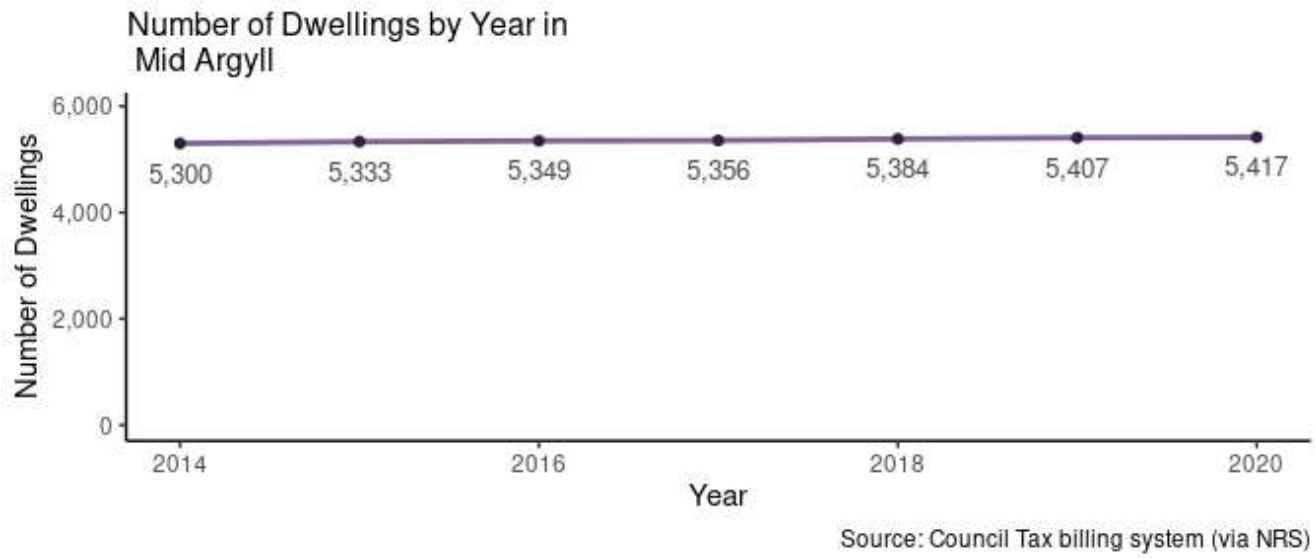
Summary:

For the most recent time periods available, Mid Argyll Locality had:

- **5,417** dwellings, of which: **87%** were occupied and **8%** were second homes.
- **32%** of dwellers received a single occupant council tax discount, and **0.79%** were exempt from council tax entirely.
- **55%** of houses were within council tax bands A to C, and **14%** were in bands F to H.

The graph below shows the number of dwellings in Mid Argyll from 2014 to 2020.

Figure 5: Number of dwellings time trend.



Of the total number of dwellings in 2020, 32% (1,737 households) were occupied by an individual receiving a single occupant council tax discount. Furthermore, 0.79% (43 households) were occupied and exempt from council tax.

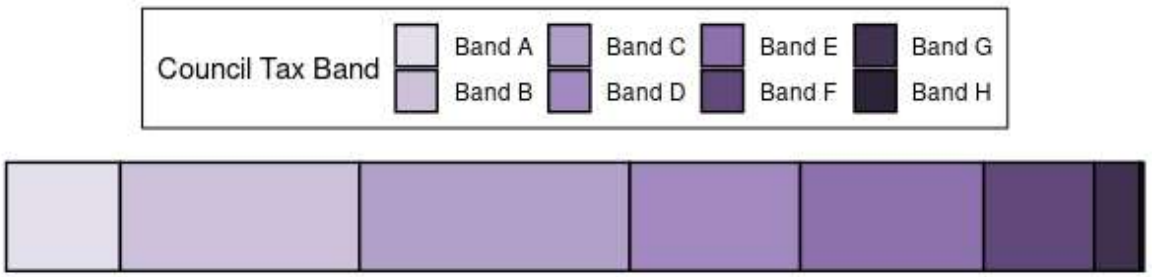
There were 431 dwellings classed as a second home in 2020, these dwellings made up 8% of the households in Mid Argyll.

Table 2: Breakdown of dwelling types by year for Mid Argyll locality.

Year	Total Dwellings	Occupied Dwellings	Vacant Dwellings	Single Occupant Tax Discount	Council Tax Exempt Dwellings	Second Homes
2014	5,300	4,603	260	1,693	43	437
2015	5,333	4,634	267	1,674	46	432
2016	5,349	4,626	286	1,703	38	437
2017	5,356	4,697	233	1,737	40	426
2018	5,384	4,711	235	1,728	46	438
2019	5,407	4,711	264	1,708	48	432
2020	5,417	4,709	278	1,737	43	431

The proportion of households within each council tax band are displayed in the chart below, figures are shown in Table 3.

Figure 6: Breakdown of households by council tax band for Mid Argyll in 2020.



Source: Scottish Assessors' Association (via NRS)

Table 3: Percentage of households by council tax band for Mid Argyll in 2020.

Tax Band	A	B	C	D	E	F	G	H
Percent of households	10%	21%	24%	15%	16%	9.7%	4%	0.35%

General Health

Summary:

For the most recent time periods available[3], Mid Argyll Locality had:

- **An average life expectancy of 78.4 years for males and 82.6 years for females.**
- **A death rate for ages 15 to 44 of 110 deaths per 100,000 age-sex standardised population[4]**
- **24%** of the locality's population with at least one long-term physical health condition.
- A cancer registration rate of **539** registrations per 100,000 age-sex standardised population[4]
- **17.61%** of the population being prescribed medication for anxiety, depression, or psychosis.

Life Expectancy

In the latest time period available from 2016-2020 (5 year aggregate), the average life expectancy in Mid Argyll locality was 78.4 years old for men, and 82.6 years old for women. A time trend since 2013-2017 can be seen in figure 8.

Figure 8: Average life expectancy in men and women over time.

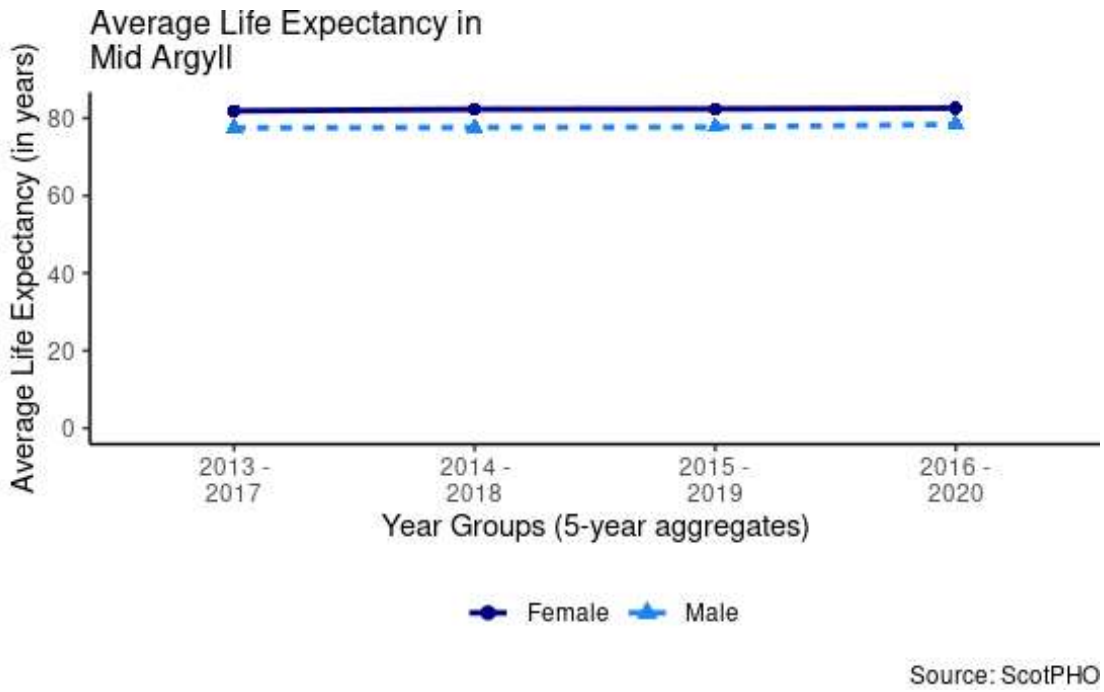


Table 5 provides the average life expectancy for men and women in different areas for the latest time period available. Please note that these are 5 year aggregates for the locality from 2016-2020, but 3 year aggregates from 2018-2020 at partnership, Health Board, and Scotland level.

Table 5: Average life expectancy in years for the latest time periods (2016-2020 aggregated years for the locality; 2018-2020 aggregated years for other areas).

	Locality	Partnership	Health Board	Scotland
	82.6	81.6	81.8	81
	78.4	78	77.6	76.8

Where Locality = Mid Argyll, Partnership = Argyll and Bute HSCP, Health Board = NHS Highland.

Deaths, aged 15-44

The following chart shows a trend of death rates among 15-44 year olds per 100,000 age-sex standardised population[4] by area (i.e. Early mortality rate per 100,000). In the most recent aggregate time period available (from 2018-2020), the mortality rate in Mid Argyll locality was **110** deaths per 100,000 population. Figure 10 then provides comparisons of deaths for all localities in Argyll and Bute HSCP, for the two latest time aggregates available.

Figure 9: Deaths aged 15-44 years by geographical area and over time.

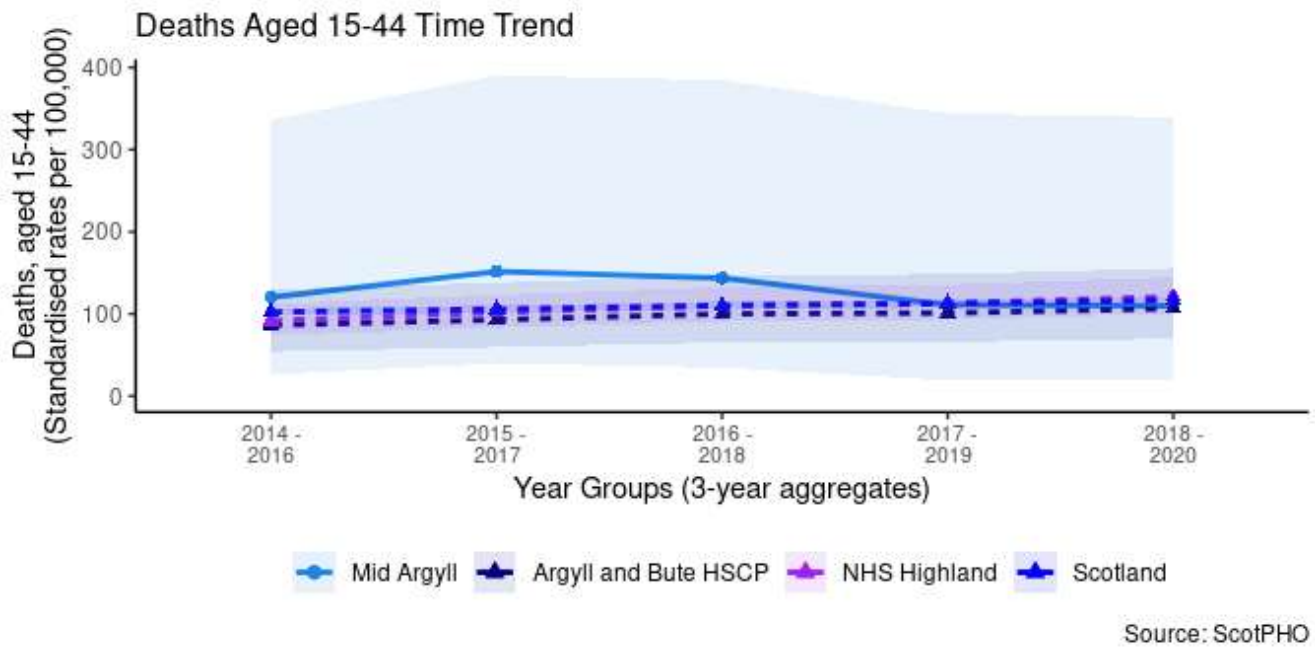
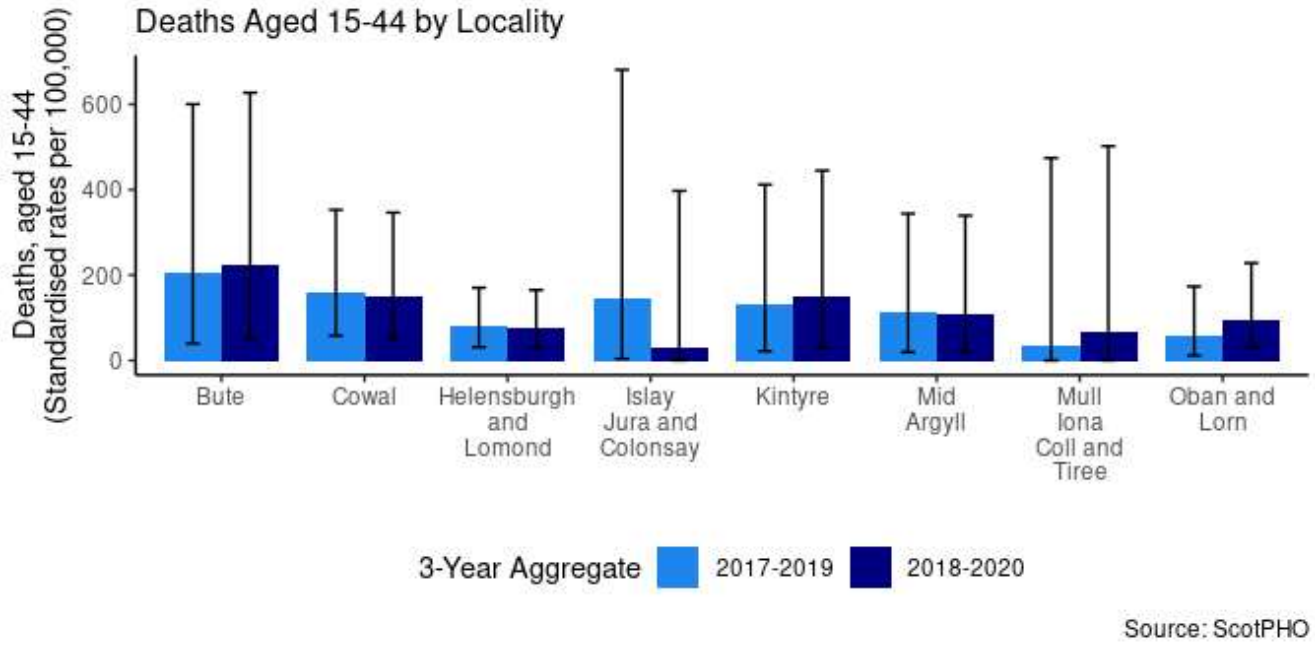
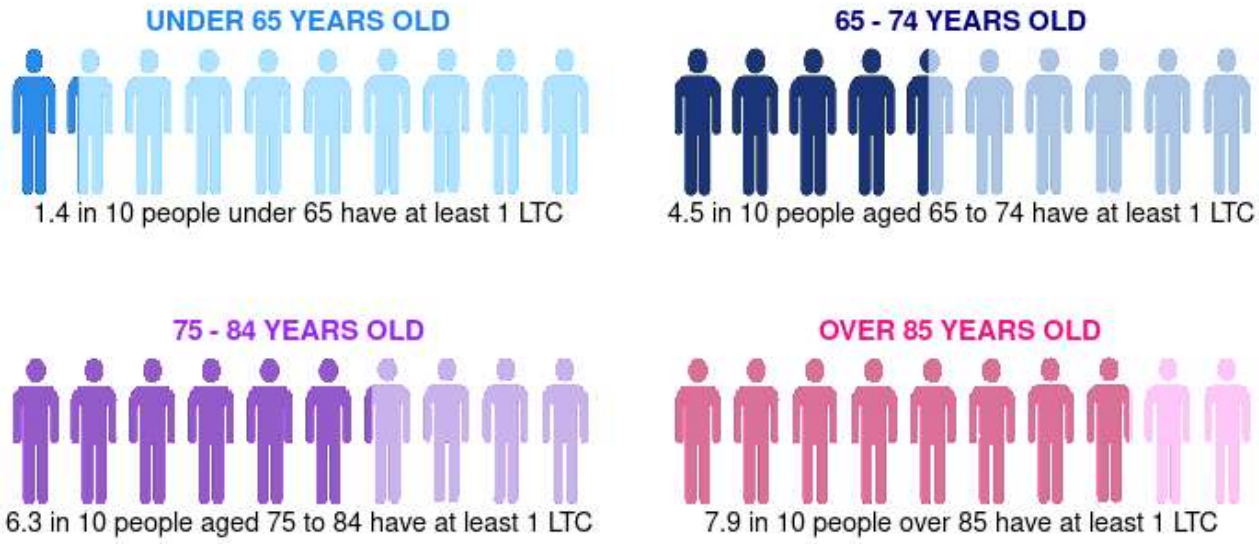


Figure 10: Deaths at ages 15-44 in Argyll and Bute HSCP localities.



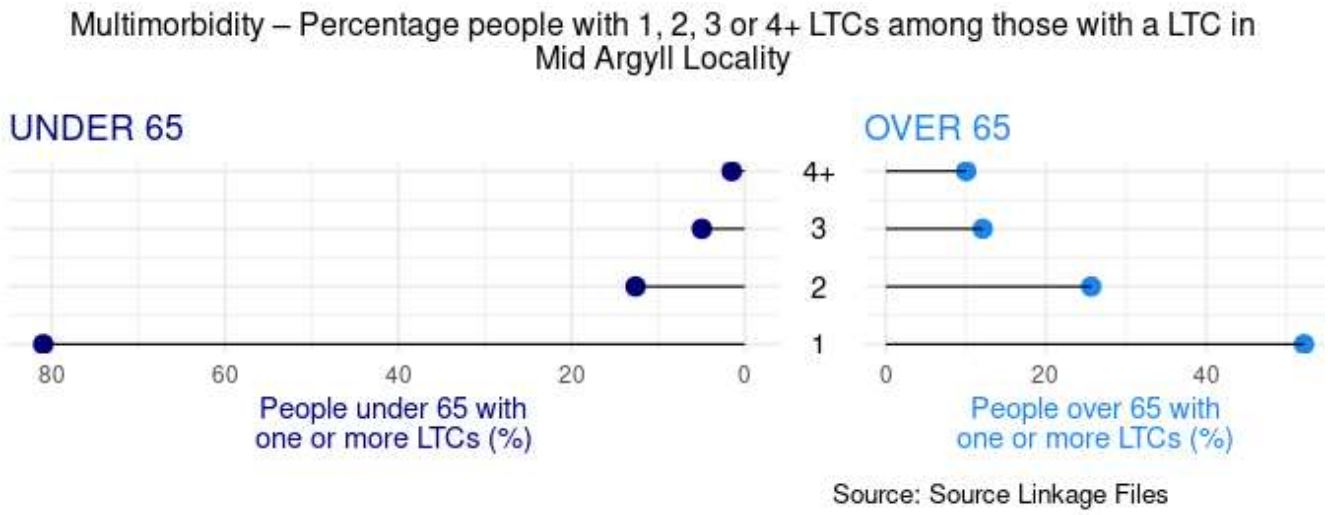
Long-Term Physical Health Conditions and Multimorbidity

In the financial year 2020/21, in Mid Argyll Locality, **24%** of the total population had at least one physical long-term condition (LTC). These include: cardiovascular, neurodegenerative, and respiratory conditions, as well as other organ conditions (namely liver disease and renal failure), arthritis, cancer, diabetes, and epilepsy. *Please see footnotes for information and caveats on identifying LTCs.*[5]



The co-occurrence of two or more conditions, known as multimorbidity, is broken down in figure 11, distinguishing between age groups. Note that this chart *excludes* the population in the locality who do not have any physical long-term conditions. Figure 13 therefore shows that among the people who have a LTC, **19**% of those under the age of 65 have more than one, compared to **48**% of those aged over 65.

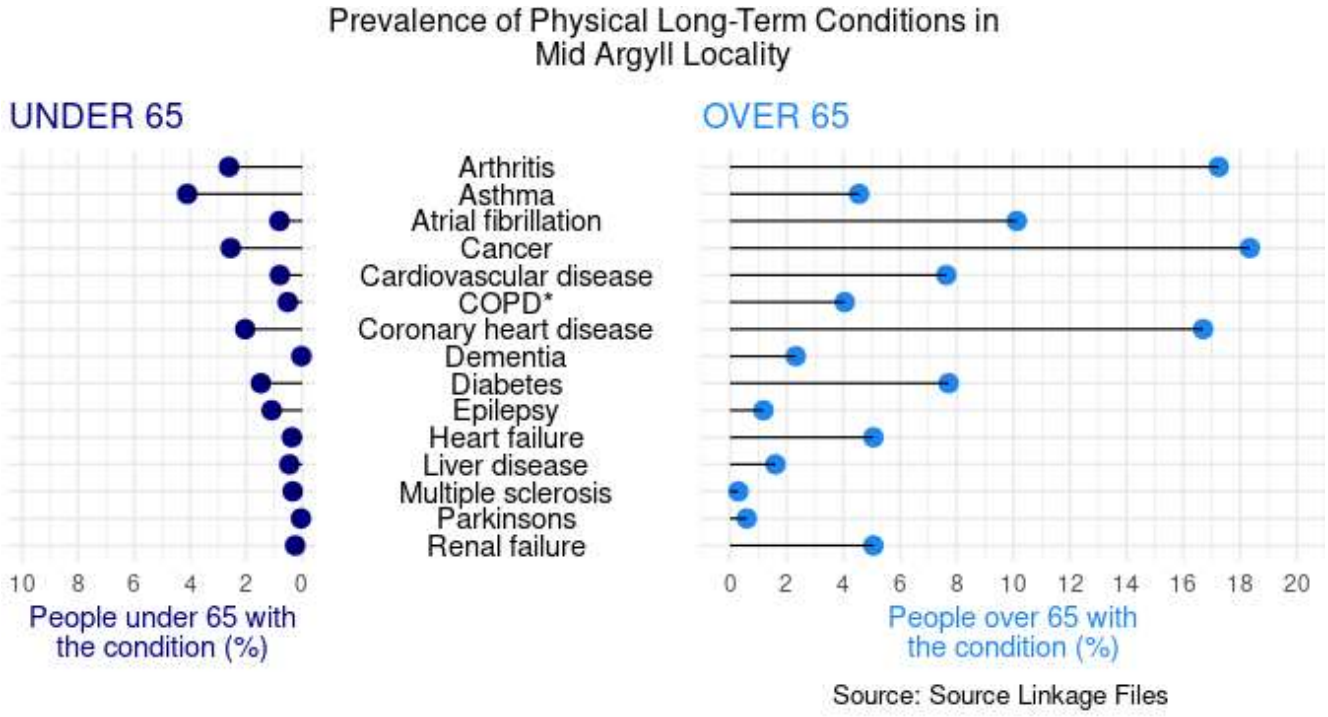
Figure 11: Multimorbidity of physical long-term conditions by age group in 2020/21.



Most common physical Long-Term Conditions (LTCs)

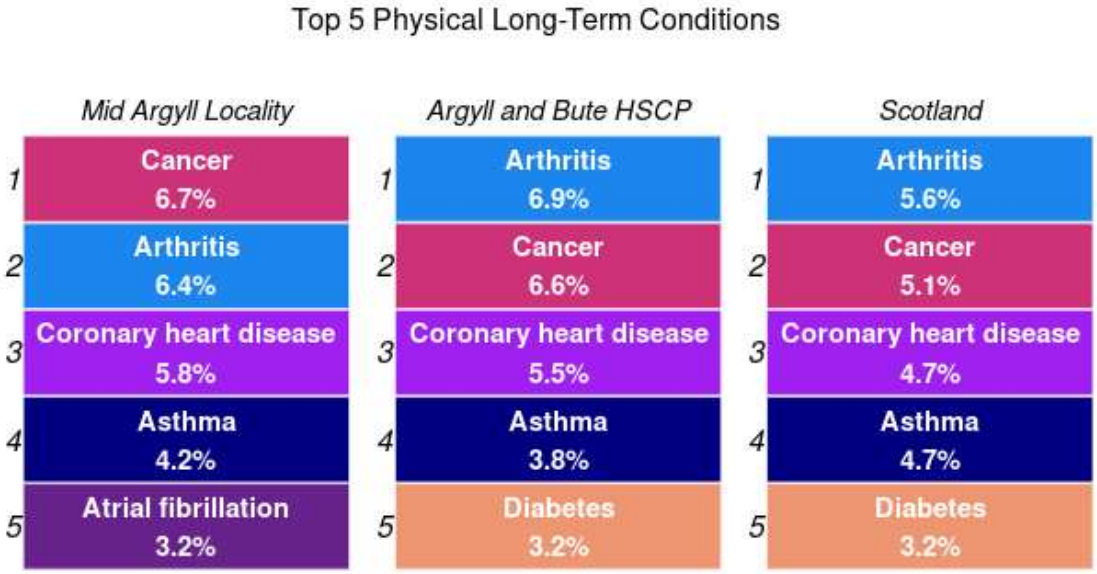
Below is a breakdown of the physical LTCs, for the financial year 2020/21. Figure 12 shows the prevalence of different LTCs in each age group in Mid Argyll locality, and Table 6 illustrates the top 5 physical LTCs across all ages at locality, partnership, and Scotland level.

Figure 12: Percentage people with each physical LTC, split by age group.



COPD: Chronic Obstructive Pulmonary Disease

Table 6: Prevalence of the five most common physical LTCs as a percentage of the population across geographical areas (where 1 = most prevalent).



Cancer Registrations

For the period 2017-2019, there were 62 new cancer registrations per year on average (**539** registrations per 100,000 age-sex standardised population) in Mid Argyll locality. This is a **0.65%** decrease in cancer registrations rate from the previous aggregate period 2016-2018. Figure 13 shows changes over time since 2014-2016, and Figure 14 compares the rates of localities in Argyll and Bute HSCP for the two latest available time periods.

Figure 13: Cancer registration rate over time and by geographical area.

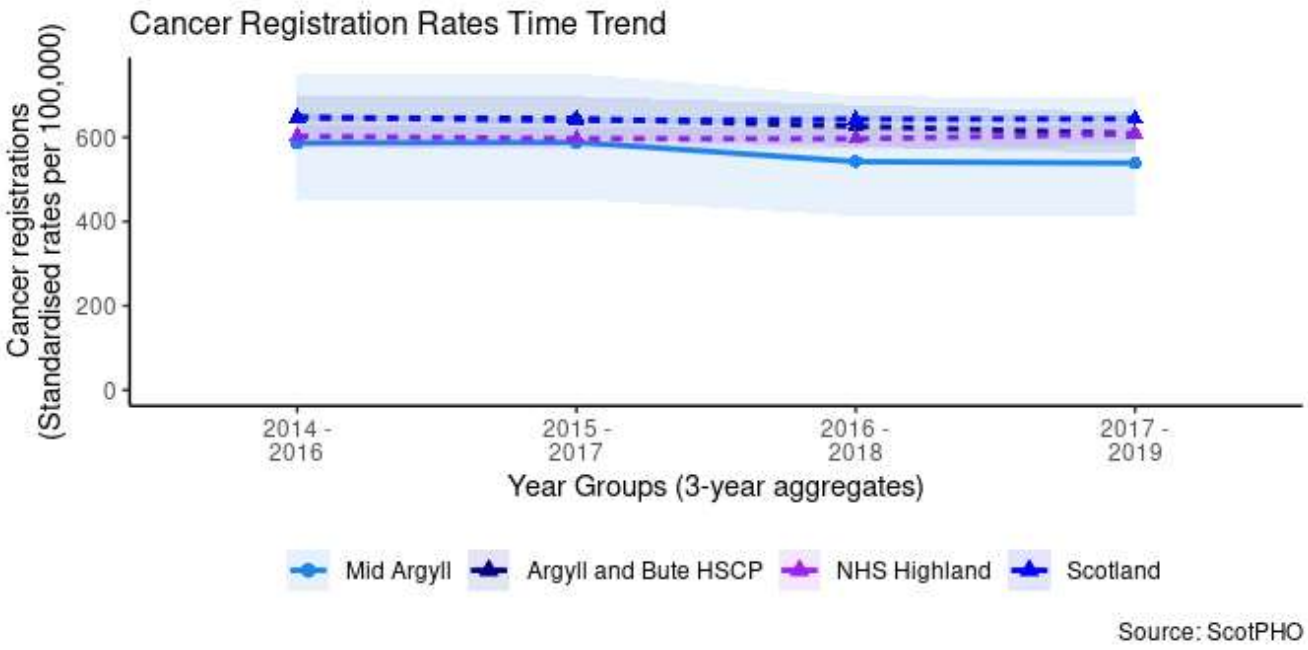
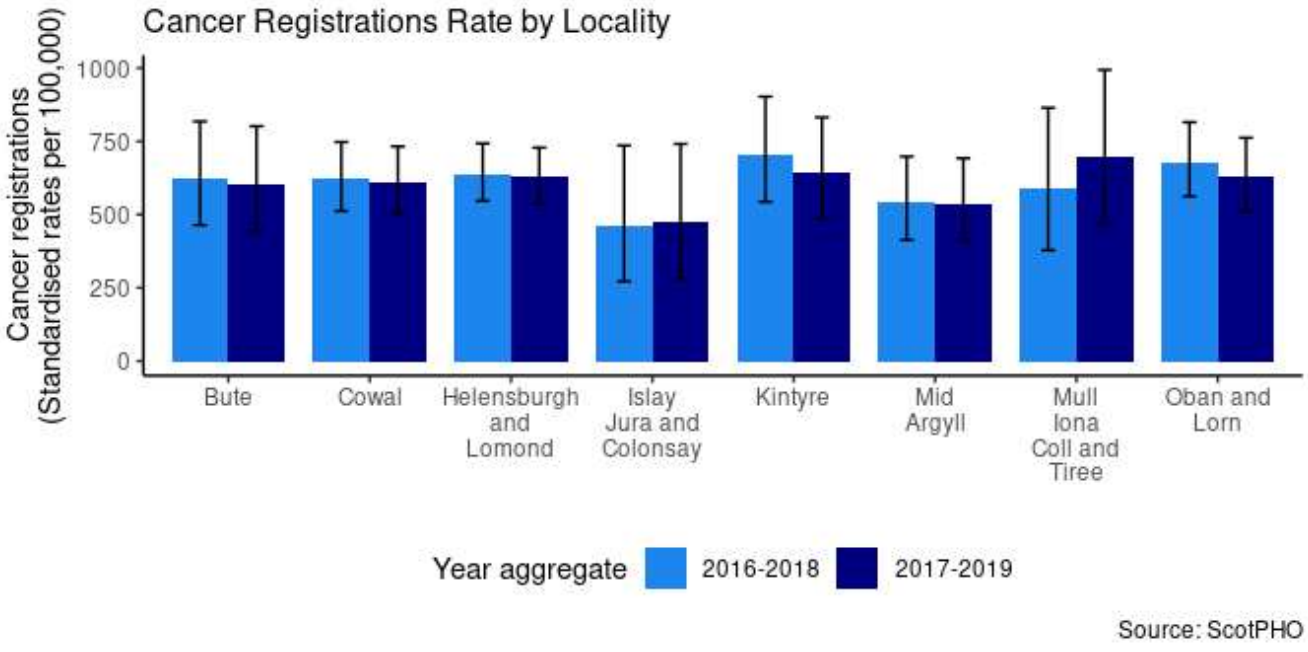


Figure 14: Cancer registration rates in Argyll and Bute HSCP localities.



Anxiety, Depression, and Psychosis Prescriptions

In the 2019/20 financial year, 17.61% of people were prescribed medication for anxiety, depression, or psychosis (ADP) in Mid Argyll Locality. This is a 4.2% increase from the previous financial year. Differences over time and between areas may relate to multiple factors, only one of which is underlying disease. Note that data are based on main original licensed use for the prescriptions and some drugs included may be prescribed for other purposes.

Figure 15: Percentage population prescribed ADP medication in Argyll and Bute HSCP localities.

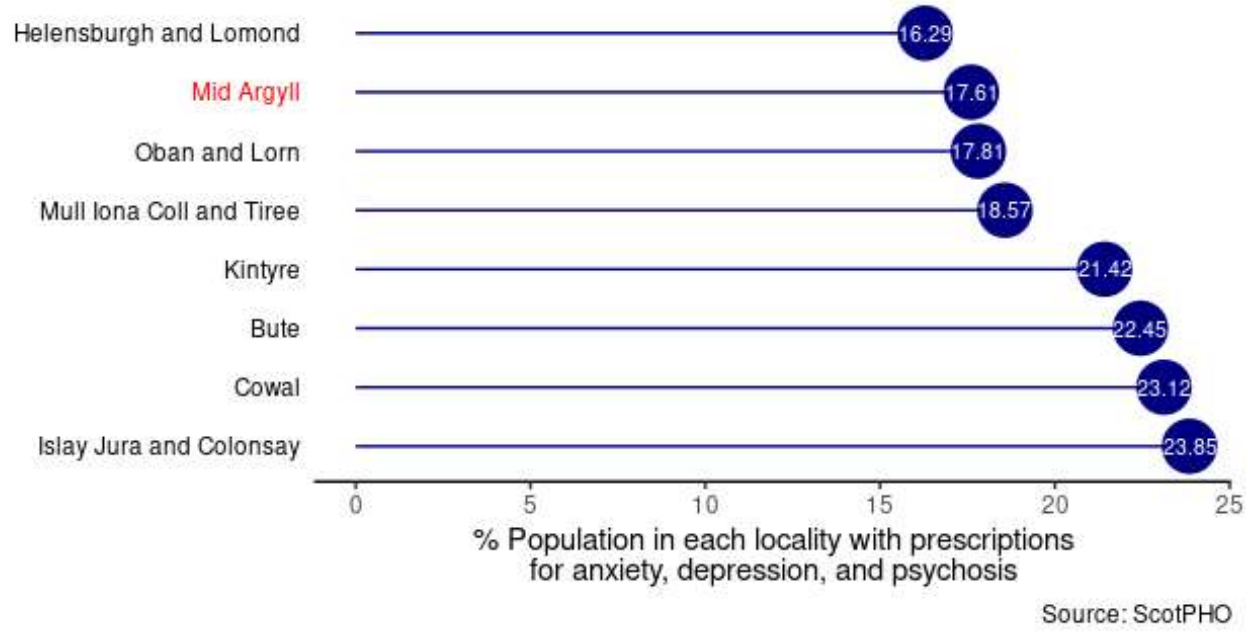
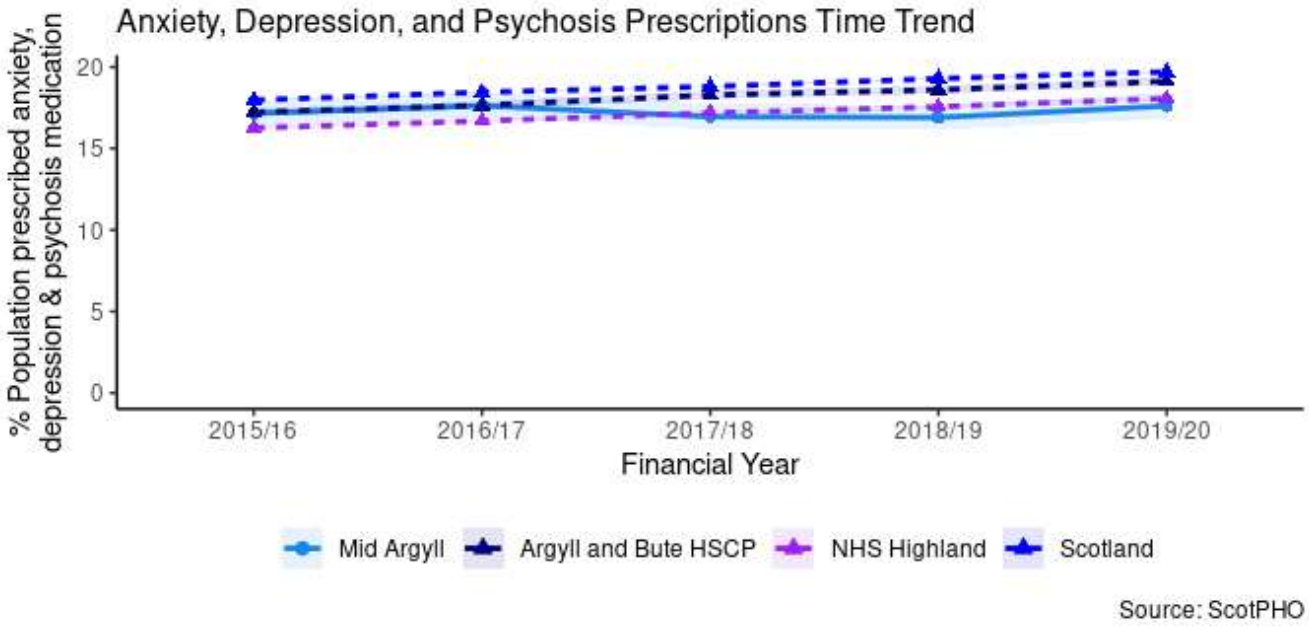


Figure 16: ADP prescriptions over time and by geographical area.



Behavioural Factors

Summary:

Mental and physical wellbeing has close ties with people's behaviours. Life circumstances including financial security, employment and location are interlinked with behavioural factors. This section provides data on drug-related hospital admissions, alcohol-related hospital admissions, alcohol-specific mortalities and bowel screening uptake, to give an overview of some behaviours known to be associated with health and wellbeing outcomes.

For the most recent time periods available[3], Mid Argyll had:

- **65** drug-related hospital admissions per 100,000 age-sex standardised population[4]. This is a lower rate of admissions than for Scotland (221).
- **620** alcohol-related hospital admissions per 100,000 age-sex standardised population[4].
- **24** alcohol-specific mortalities per 100,000 age-sex standardised population[4].
- a **63%** uptake of bowel cancer screening for the eligible population.

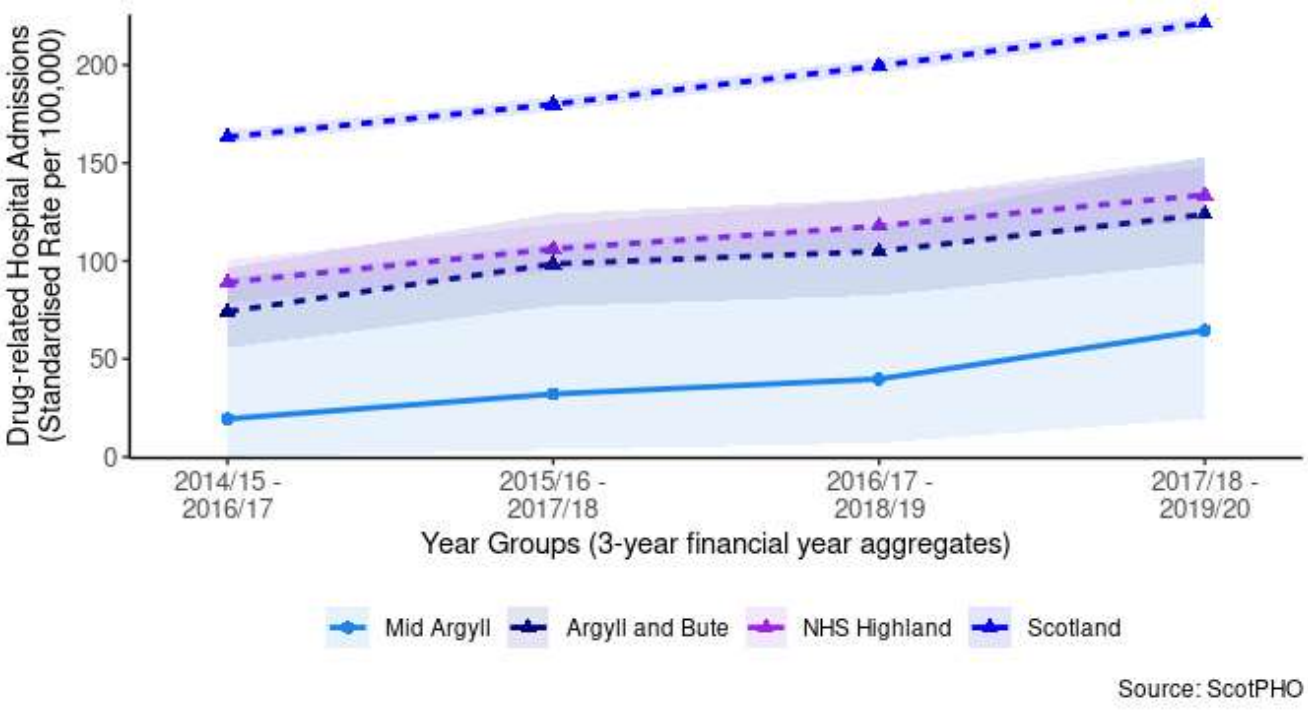
Drug-related Hospital Admissions

There were 65 drug-related hospital admissions per 100,000 age-sex standardised population[4] in Mid Argyll locality for the most recent time period available (3 year financial year aggregate for 2017/18 - 2019/20).

This is a 242% increase since 2014/15 - 2016/17 (3 financial year aggregates).

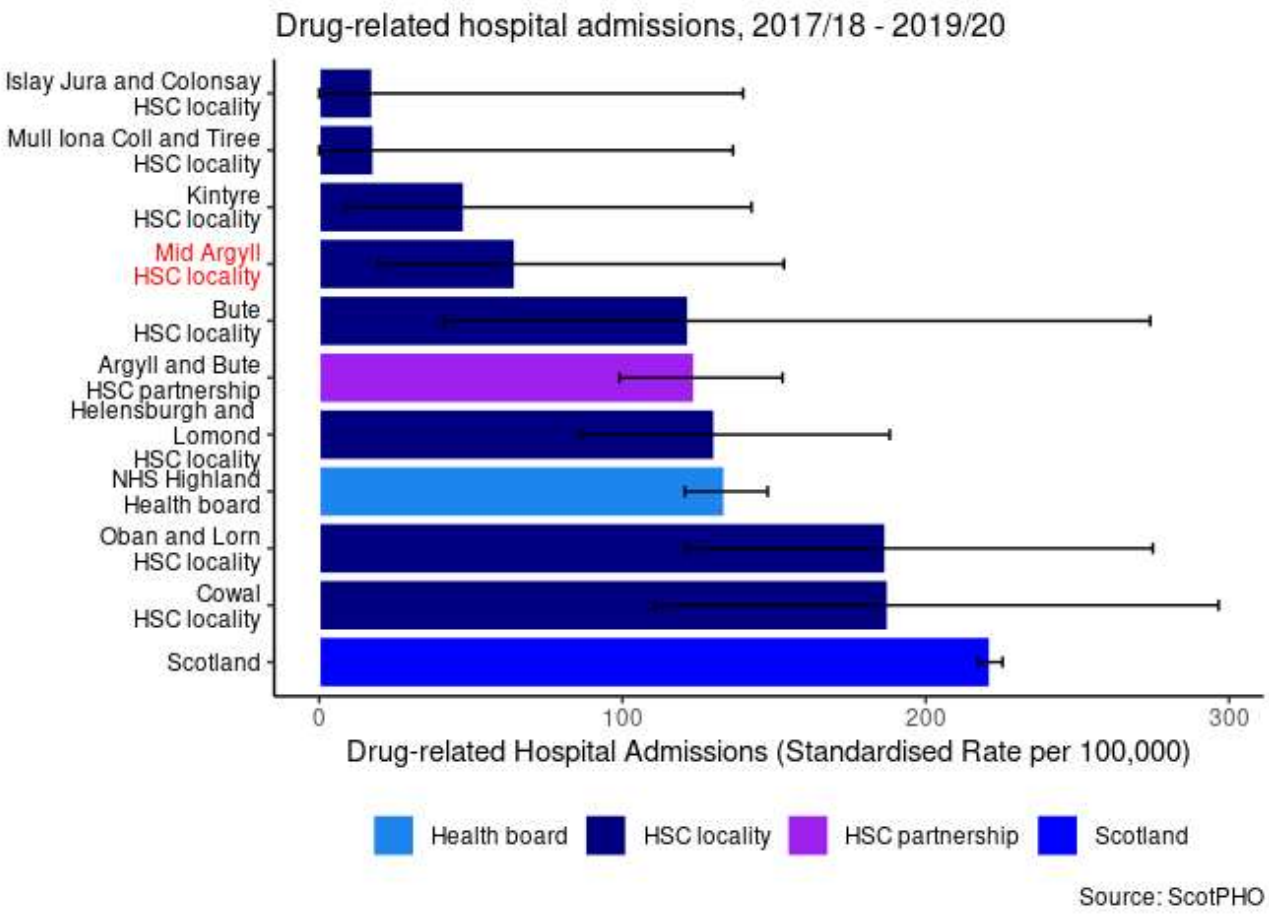
A trend of the change in drug-related hospital admissions for Mid Argyll locality compared with Scotland, Argyll and Bute HSCP and NHS Highland is shown in the chart below from 2014/15 - 2016/17 onwards.

Figure 17: Trend of Drug-related Hospital Admission Rates by geographical area.



A comparison of areas at the most recent time period (2017/18 - 2019/20 aggregated financial years) is available below. This shows Mid Argyll locality has a lower rate of admissions (65) than Argyll and Bute Partnership (124), and a lower rate of admissions than Scotland (221) overall.

Figure 18: Comparison of Drug-related Hospital Admission Rates for the period 2017/18 - 2019/20.

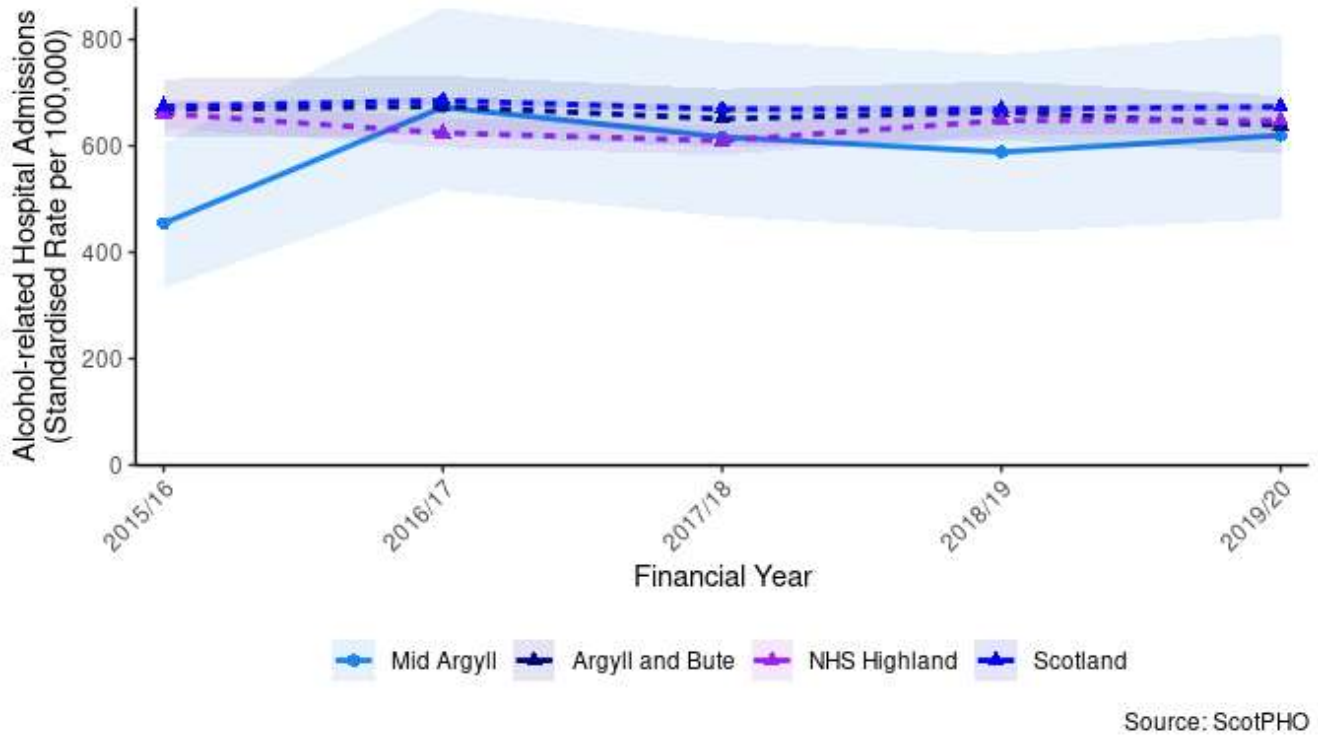


Alcohol-related Hospital Admissions

The 2019/20 alcohol-related admissions rate is 620 per 100,000 age-sex standardised population[4], which is a 36% increase overall since 2015/16.

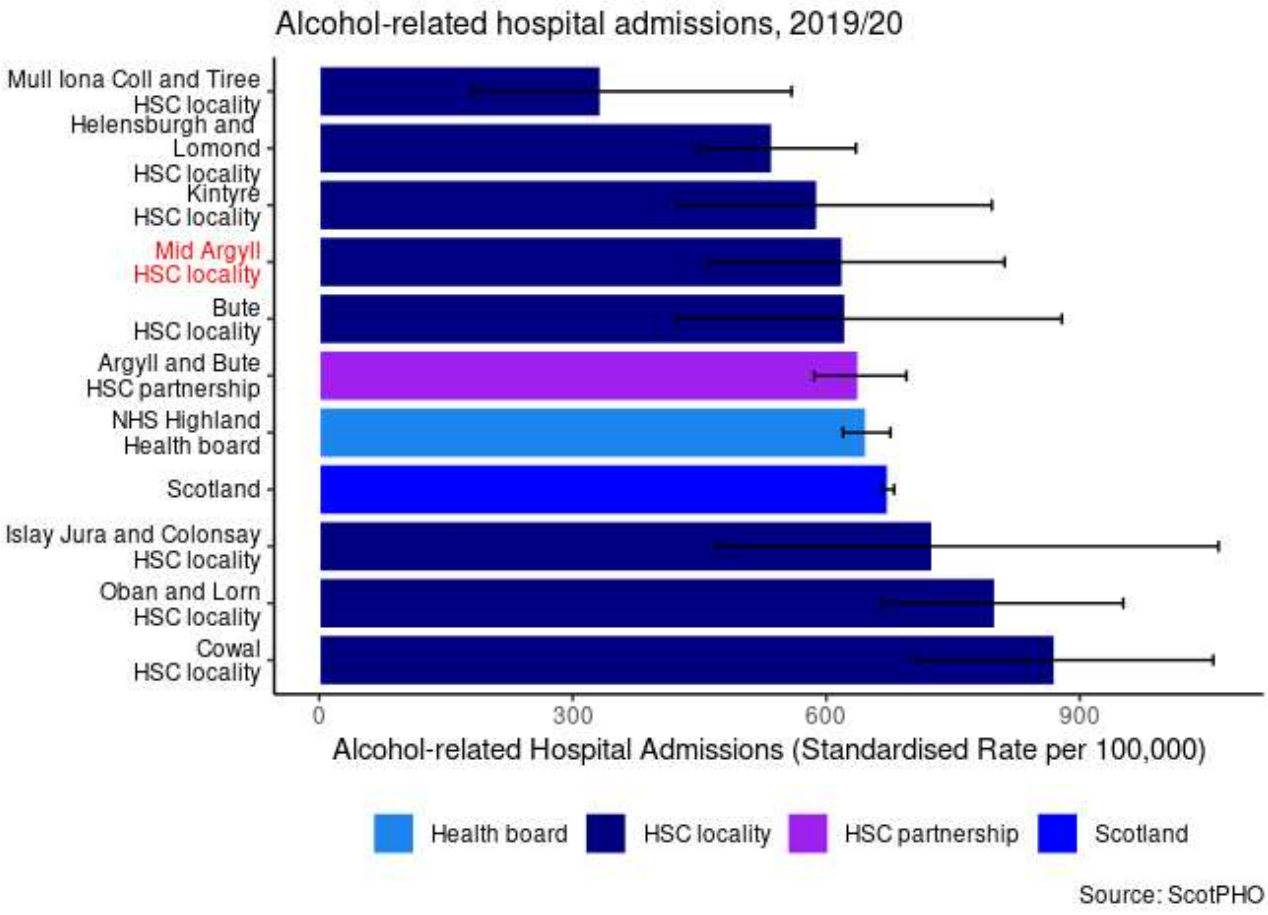
The chart below shows a trend of alcohol-related hospital admissions for Mid Argyll locality compared with Scotland, Argyll and Bute Partnership and NHS Highland from financial year 2015/16 to 2019/20.

Figure 19: Trend of Alcohol-related Hospital Admission Rates by geographical area.



Comparison across different areas for 2019/20 is shown in Figure 20. This shows that Mid Argyll locality had a lower alcohol-related hospital admissions rate (620) compared to Scotland (673).

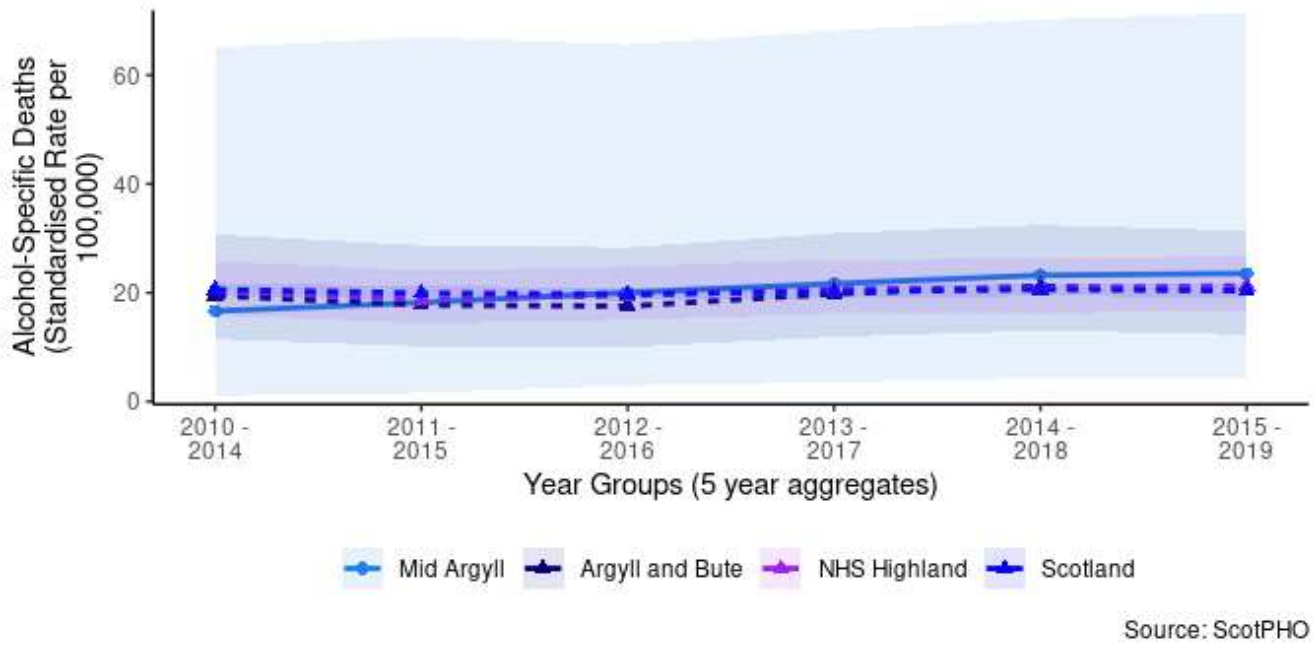
Figure 20: Comparison of Alcohol-related Hospital Admission Rates for 2019/20.



Alcohol-Specific Deaths

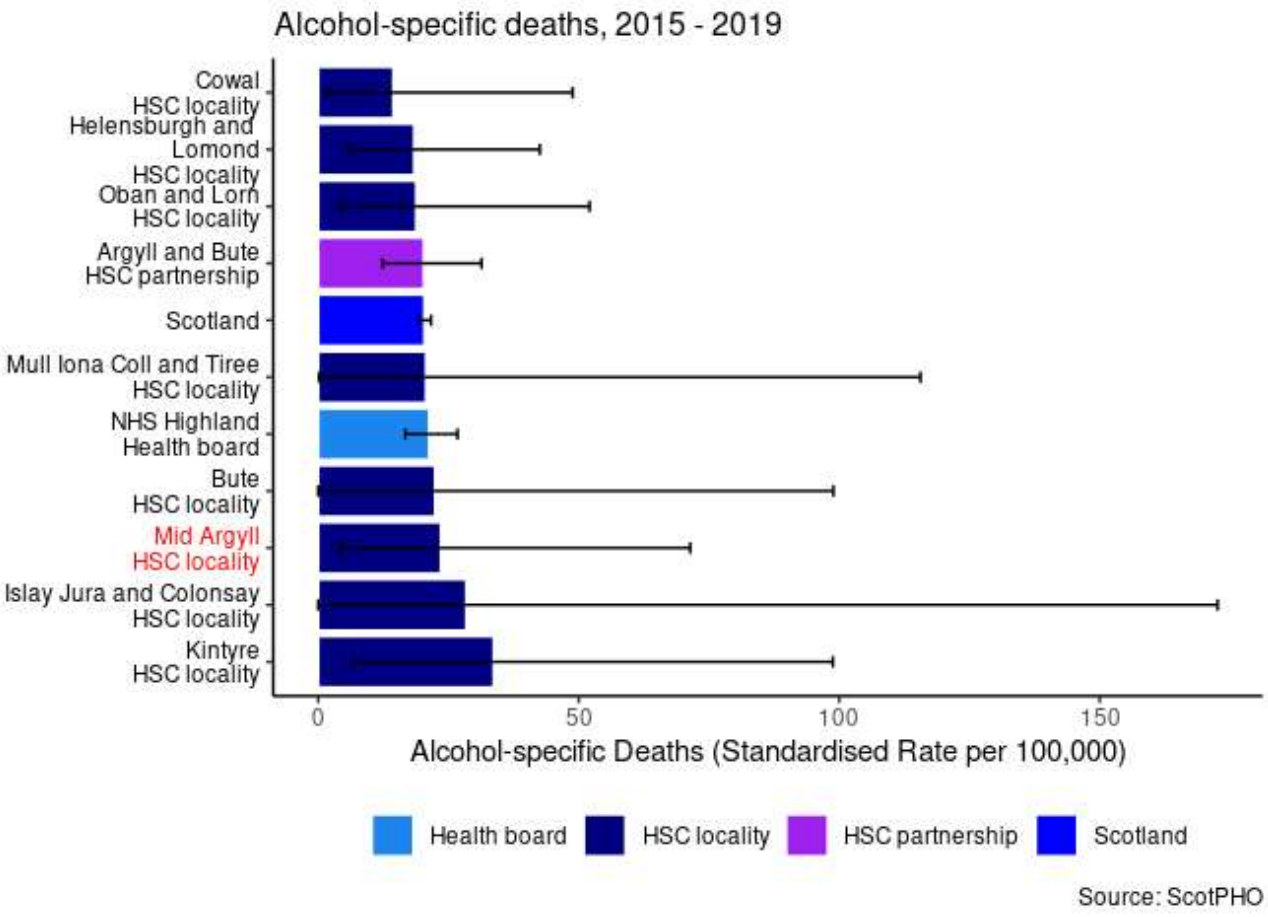
Data on alcohol-specific deaths is available as 5 year aggregates. The rate of alcohol-specific deaths is currently higher in Mid Argyll than the rate in 2010 - 2014 (42% change).

Figure 21: Trend of Alcohol-Specific Death Rates by geographical area.



A comparison across different areas illustrates that Mid Argyll locality has a higher alcohol-specific death rate compared to Scotland as a whole.

Figure 22: Comparison of Alcohol-related Death Rates for the period 2015 - 2019 (5 year aggregate).

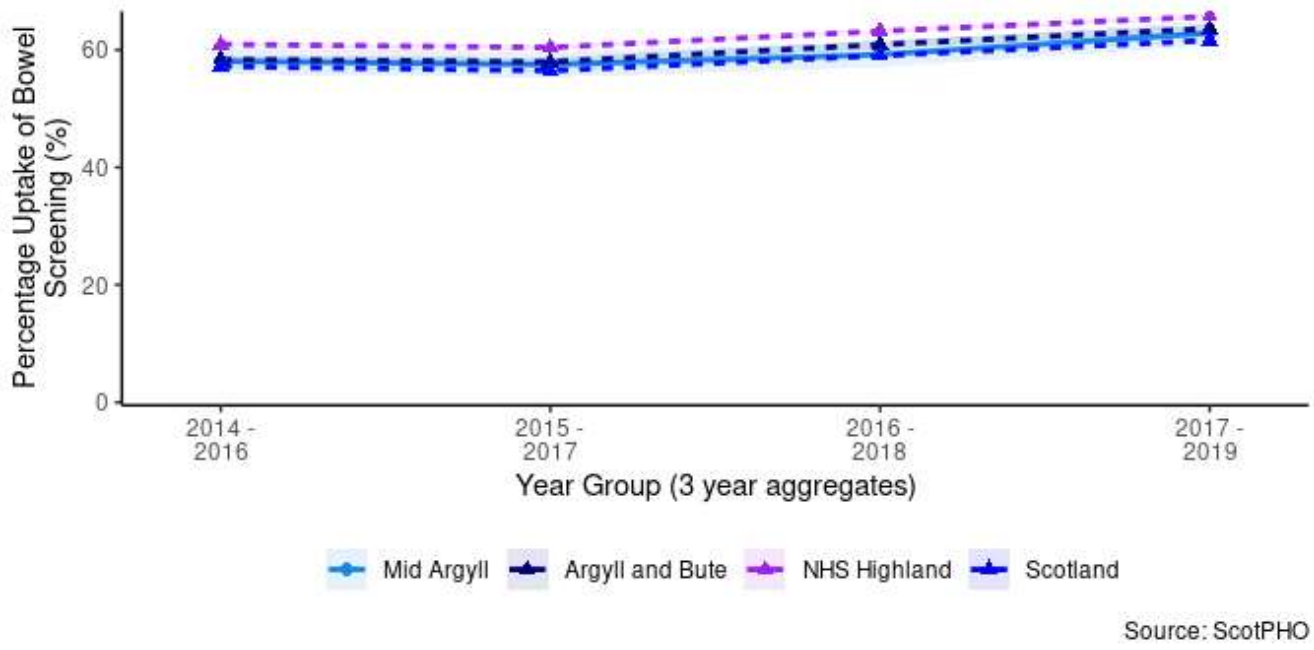


Bowel Screening Uptake

Bowel screening is offered every two years to eligible men and women aged between 50-74 years old. Eligible people are posted a test kit which is completed at home. Since 1st April 2013, those aged 75 and over can also self-refer and opt into screening.

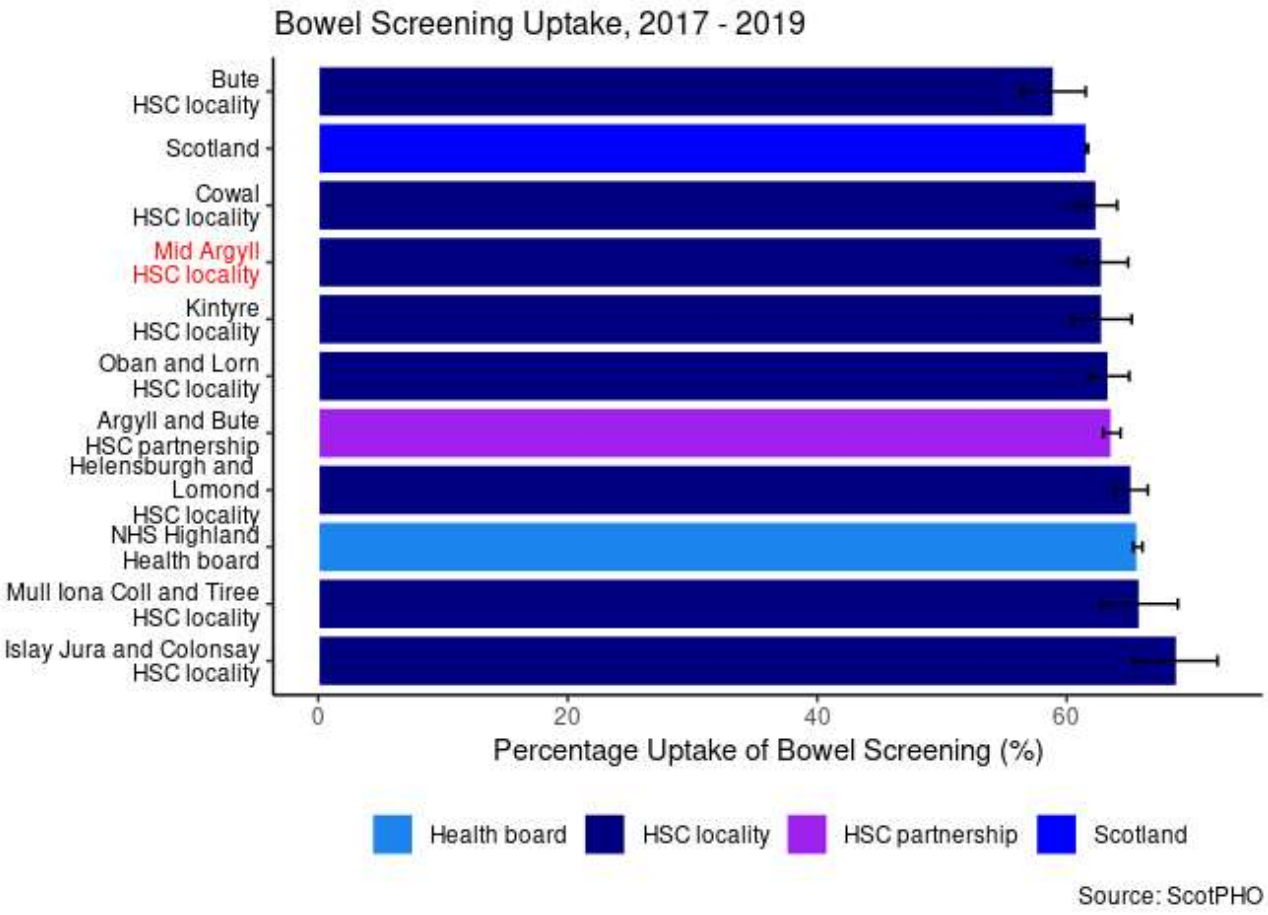
A trend of the percentage uptake of bowel screening among the eligible population is shown below for Mid Argyll locality compared with Scotland, Argyll and Bute HSCP and NHS Highland. Data is suppressed into 3 year aggregates. The 2017 - 2019 uptake rate for Mid Argyll is **63%**.

Figure 23: Trend of Bowel Screening Uptake for eligible men and women, by geographical area.



Compared with Scotland, Mid Argyll locality has a higher percentage uptake of bowel cancer screening for the period 2017 - 2019.

Figure 24: Comparison of Bowel Screening Uptake for 2017 - 2019.



Hospital and Community Care

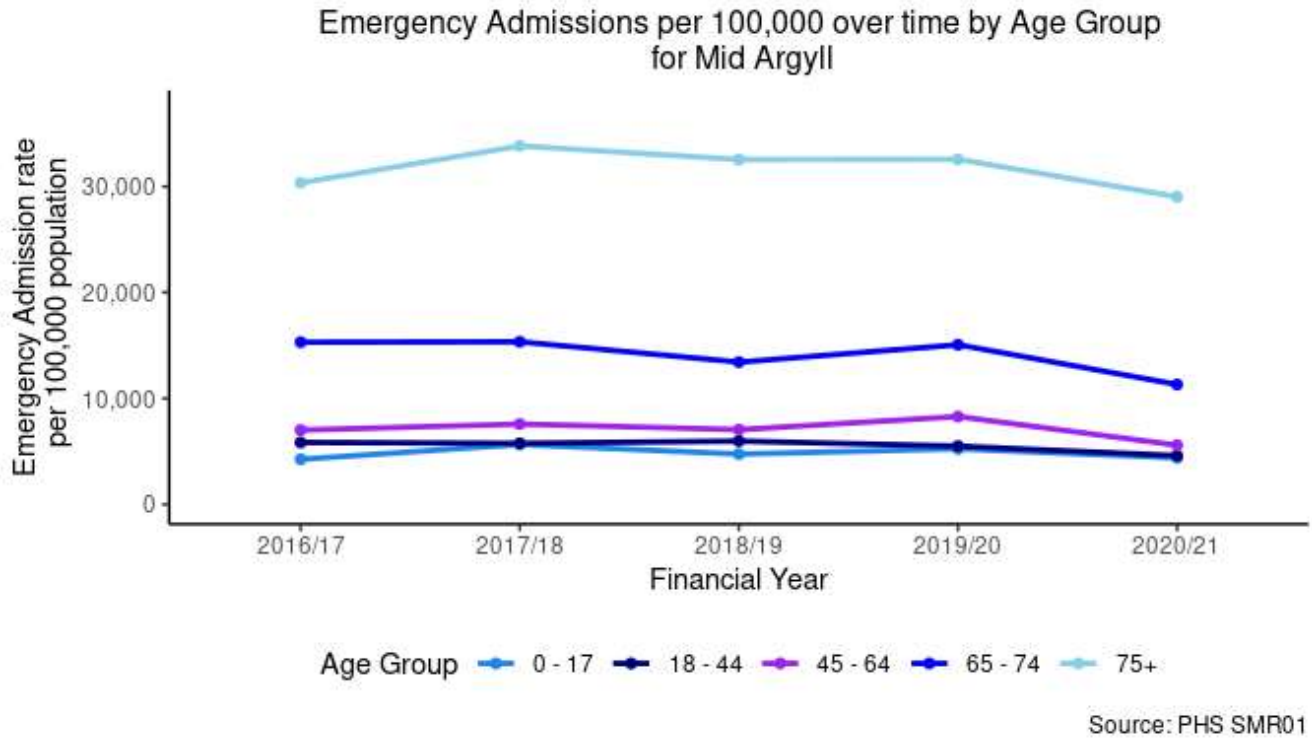
This section includes acute hospital data, delayed discharge bed days and A&E attendances. Please note that for 2020 onwards, hospital activity would have been severely affected by the COVID-19 pandemic. Information on how this has had a wider impact is provided in Footnote 6 at the end of the document.

For the most recent time periods available, Mid Argyll had:

- **8,763** emergency hospital admissions per 100,000 population.
- **54,859** unscheduled acute specialty bed days per 100,000 population.
- **4,891** A&E attendances per 100,000 population.
- **9,837** delayed discharge bed days per 100,000 population.
- **998** emergency hospital admissions from falls per 100,000 population.
- **92** emergency readmissions (28 day) per 1,000 discharges.
- **823** potentially preventable hospital admissions per 100,000 population.
- People on average spent **92%** of their last 6 months of life in a community setting.

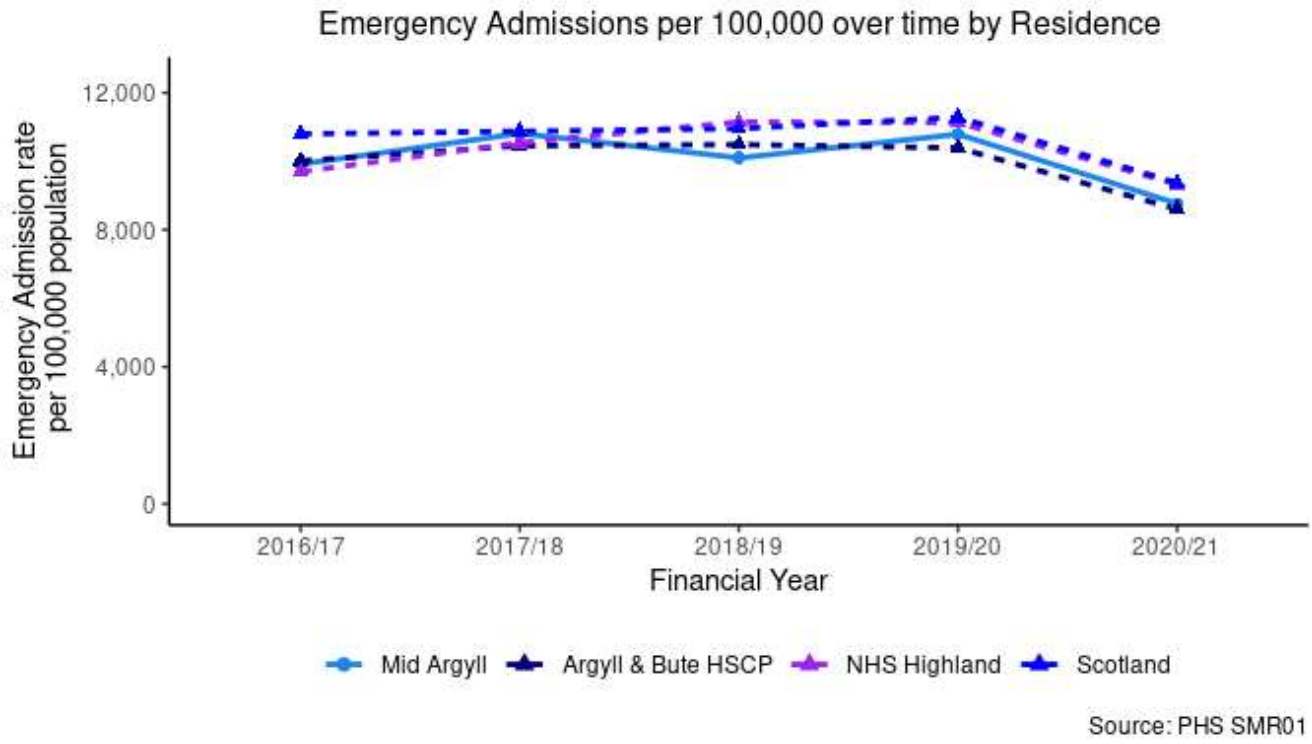
Emergency Admissions

Figure 25: Emergency admissions by age group



Source: PHS SMR01

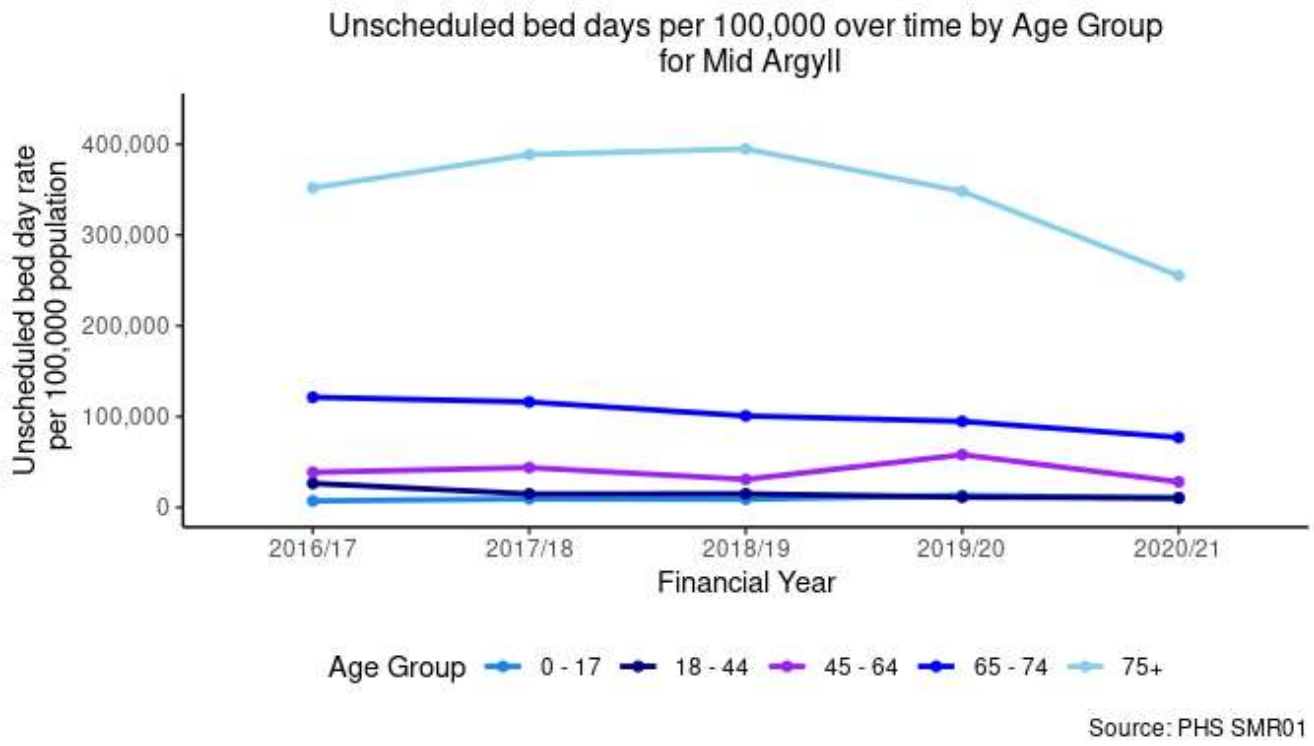
Figure 26: Emergency admissions by geographical area



Source: PHS SMR01

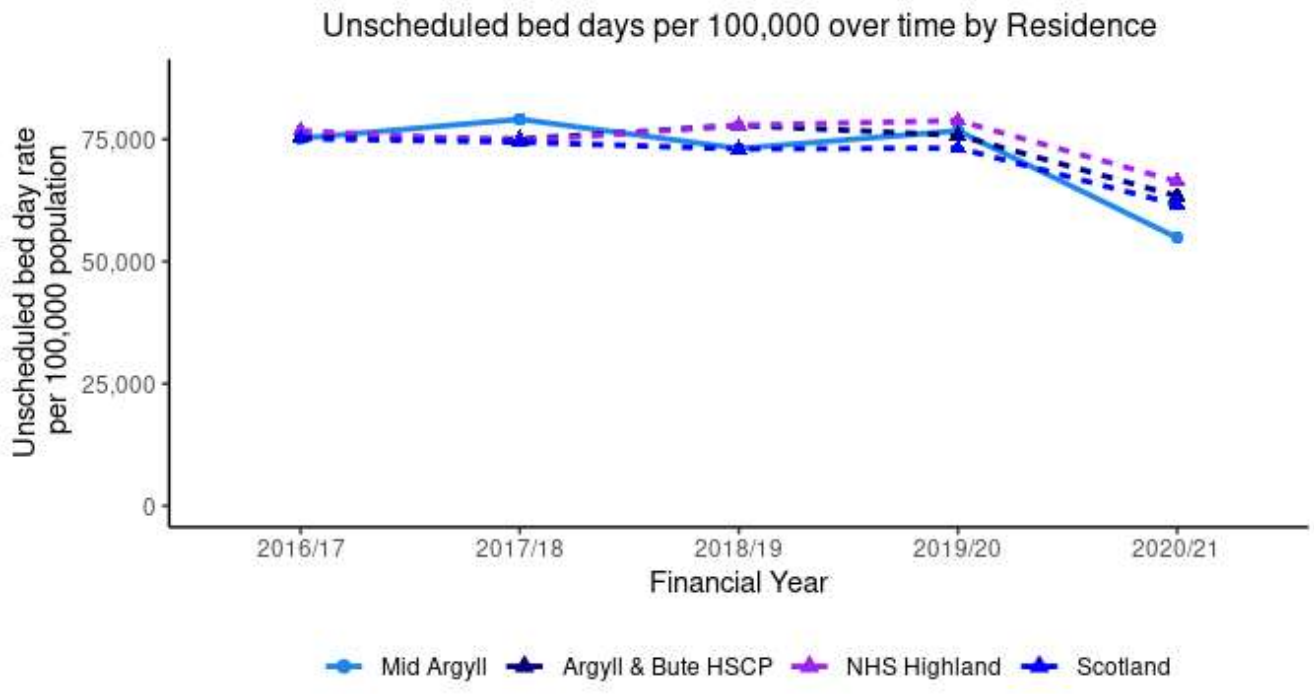
Unscheduled Acute Bed Days

Figure 27: Unscheduled bed days by age group



Source: PHS SMR01

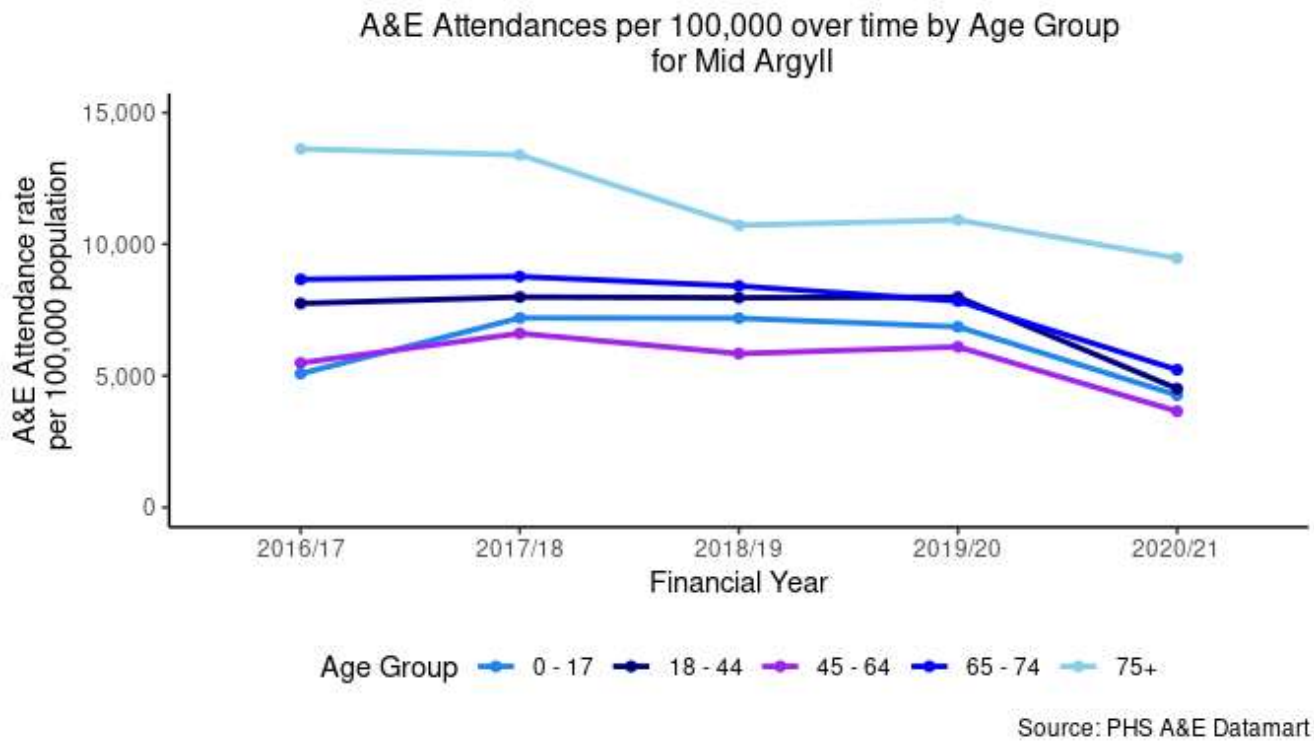
Figure 28: Unscheduled bed days by geographical area



Source: PHS SMR01

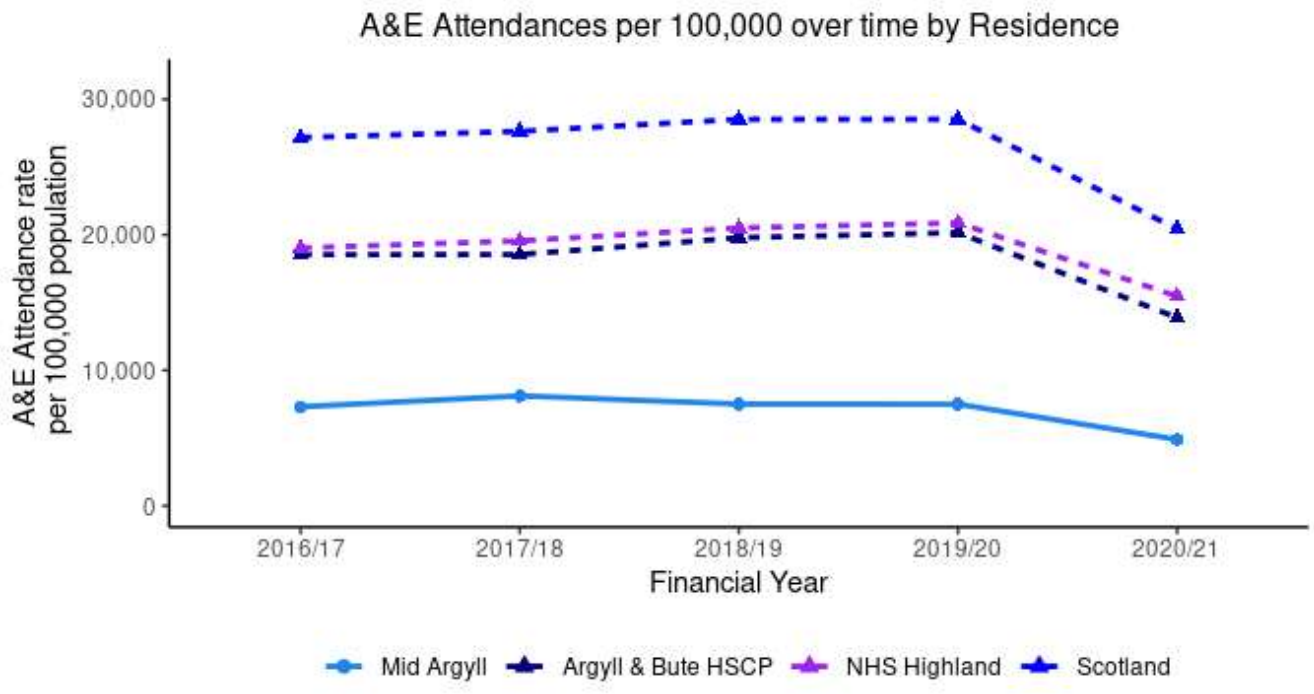
A&E Attendances

Figure 29: A&E attendances by age group



Source: PHS A&E Datamart

Figure 30: A&E attendances by geographical area



Source: PHS A&E Datamart

Delayed Discharge Bed Days

Figure 31: Delayed discharge bed days by age group

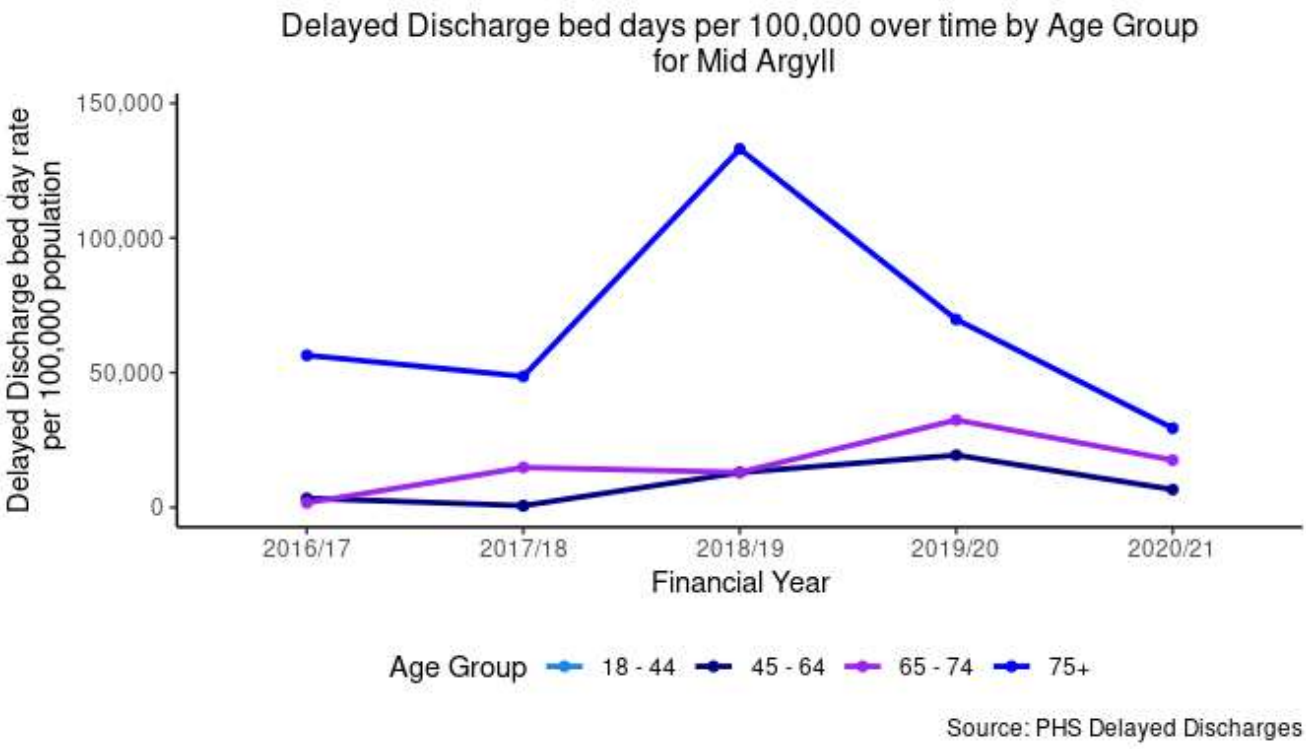
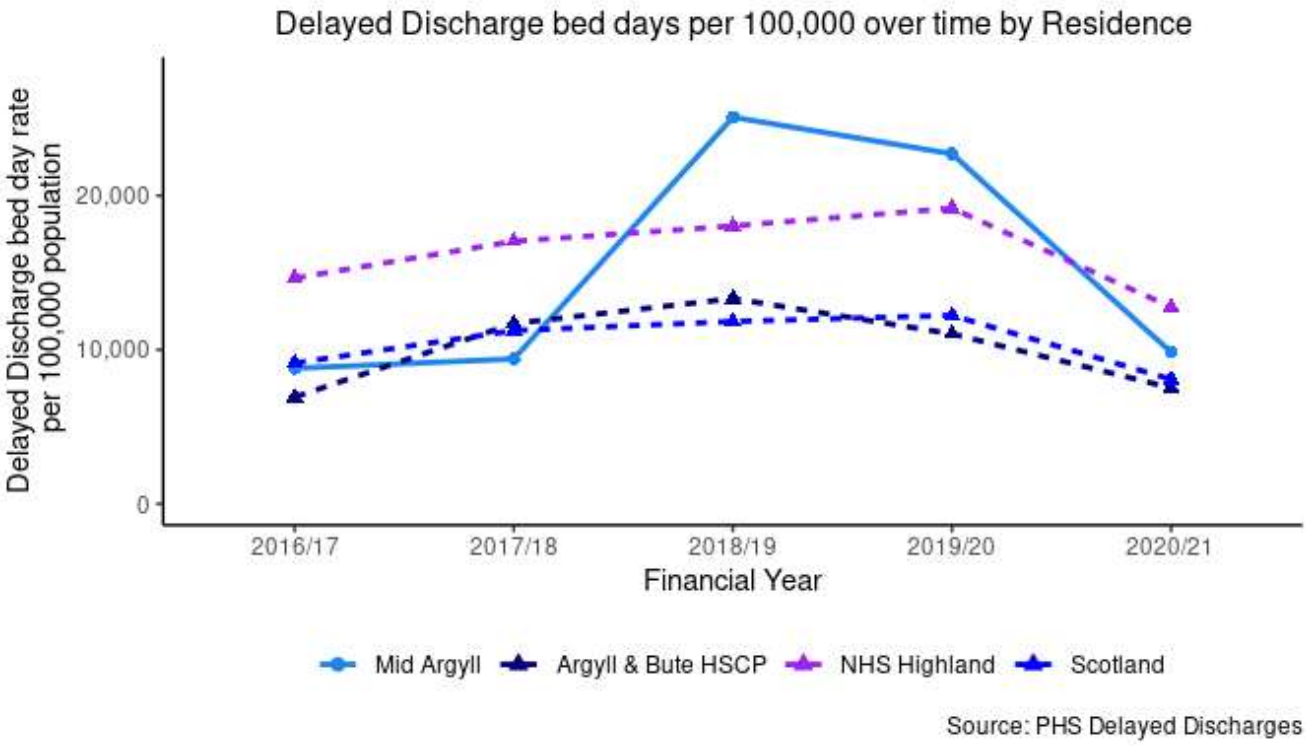


Figure 32: Delayed discharge bed days by geographical area



Emergency Admissions from a Fall

Figure 33: Falls by age group

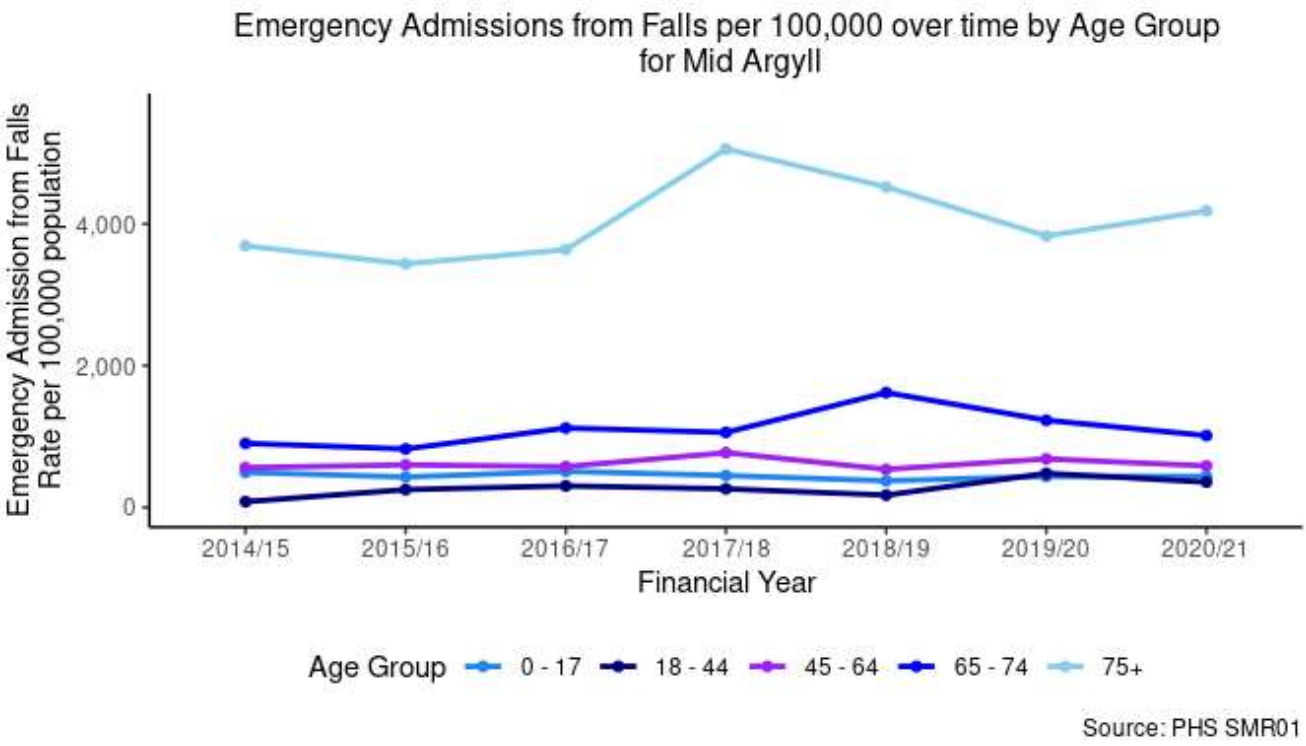
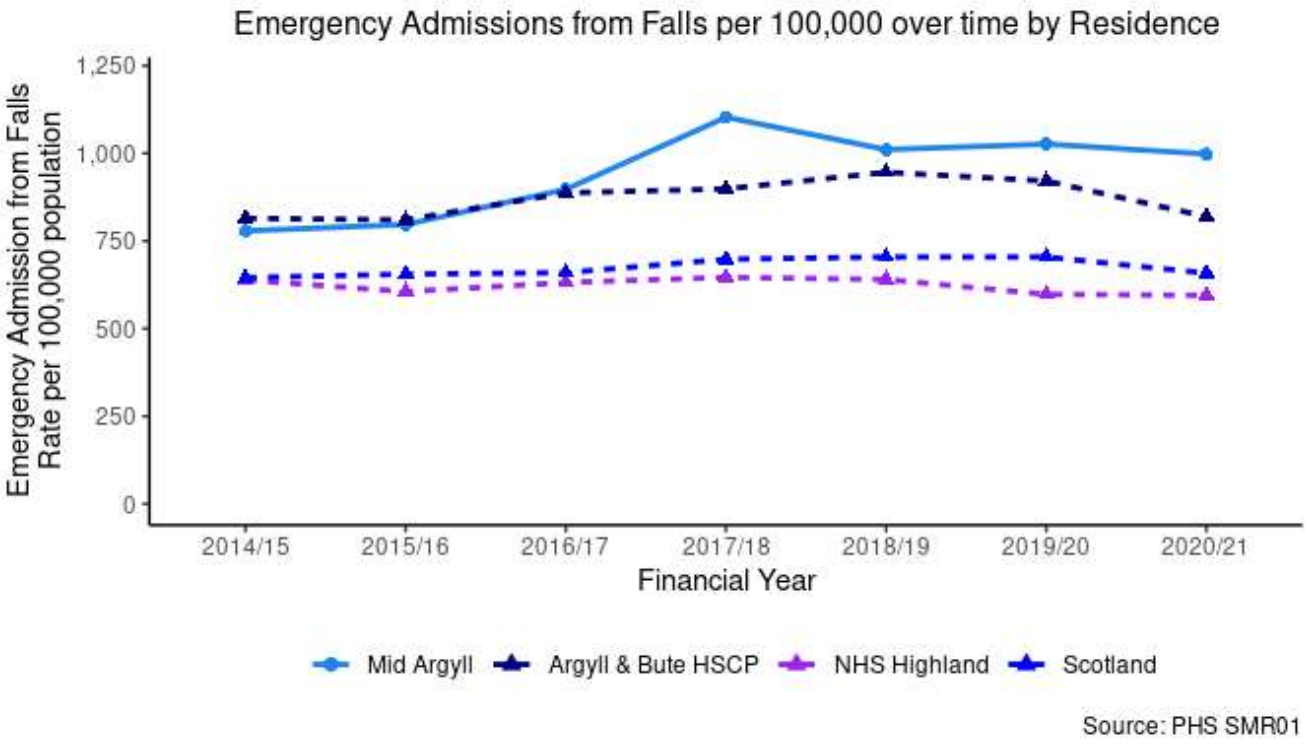
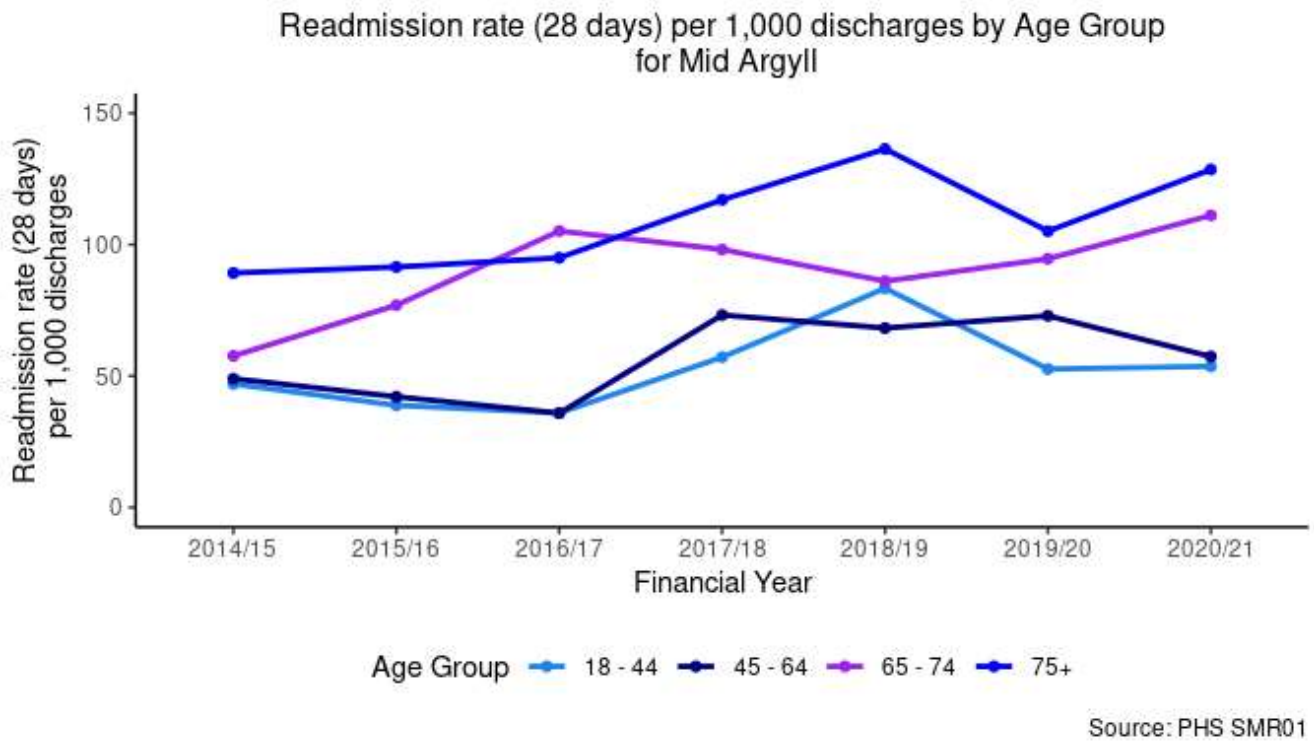


Figure 34: Falls by geographical area



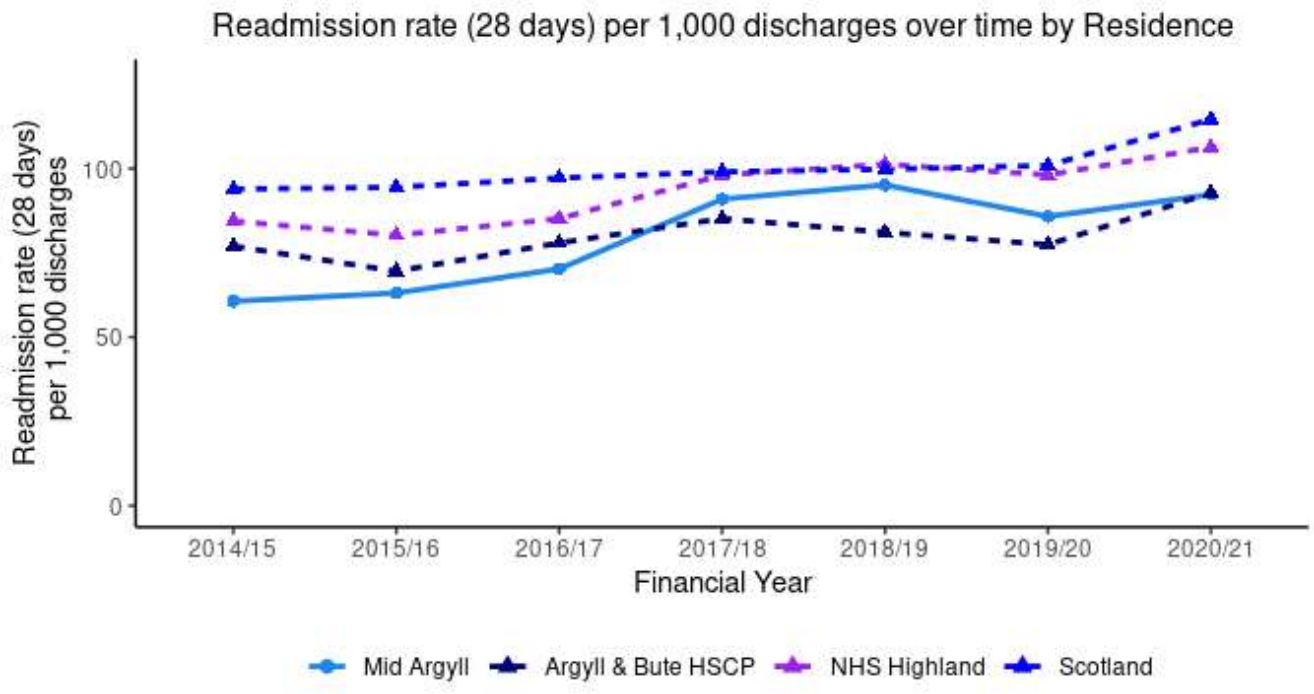
Emergency Readmissions (28 days)

Figure 35: Emergency readmissions by age group



Source: PHS SMR01

Figure 36: Emergency readmissions by geographical area

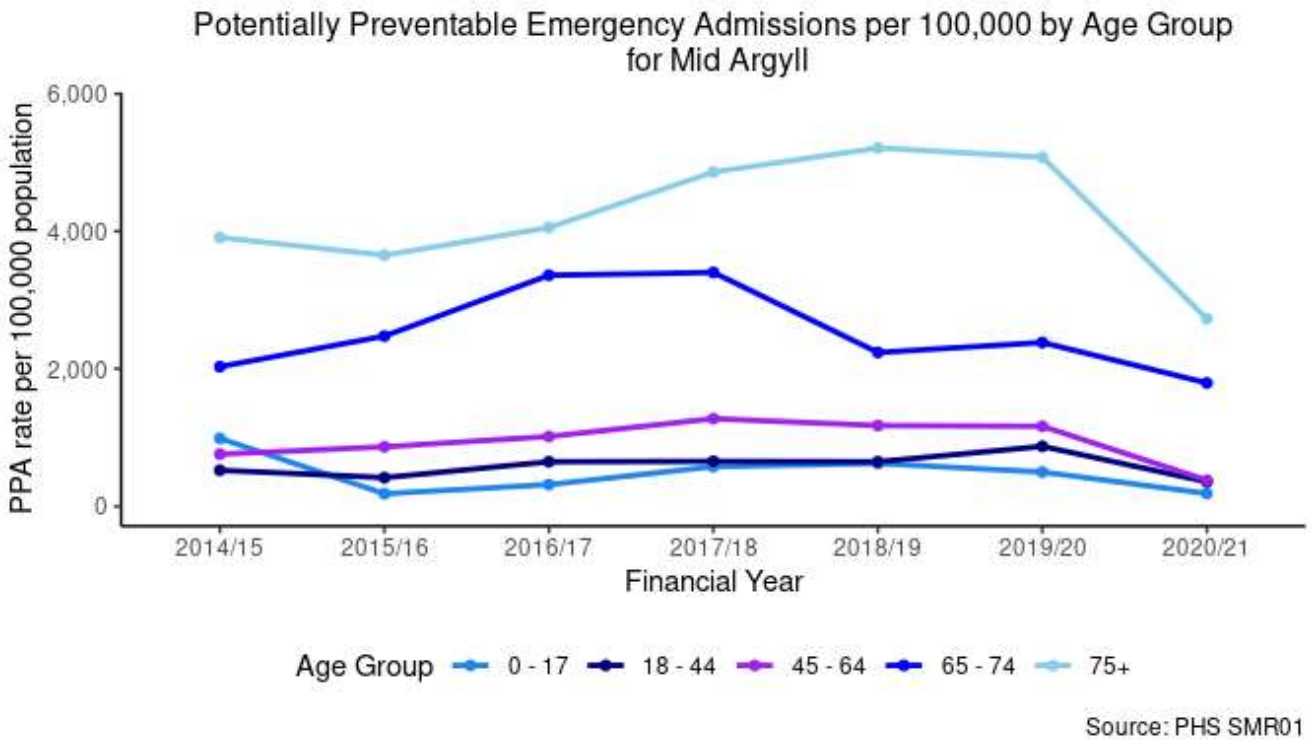


Source: PHS SMR01

Potentially Preventable Admissions (PPAs)

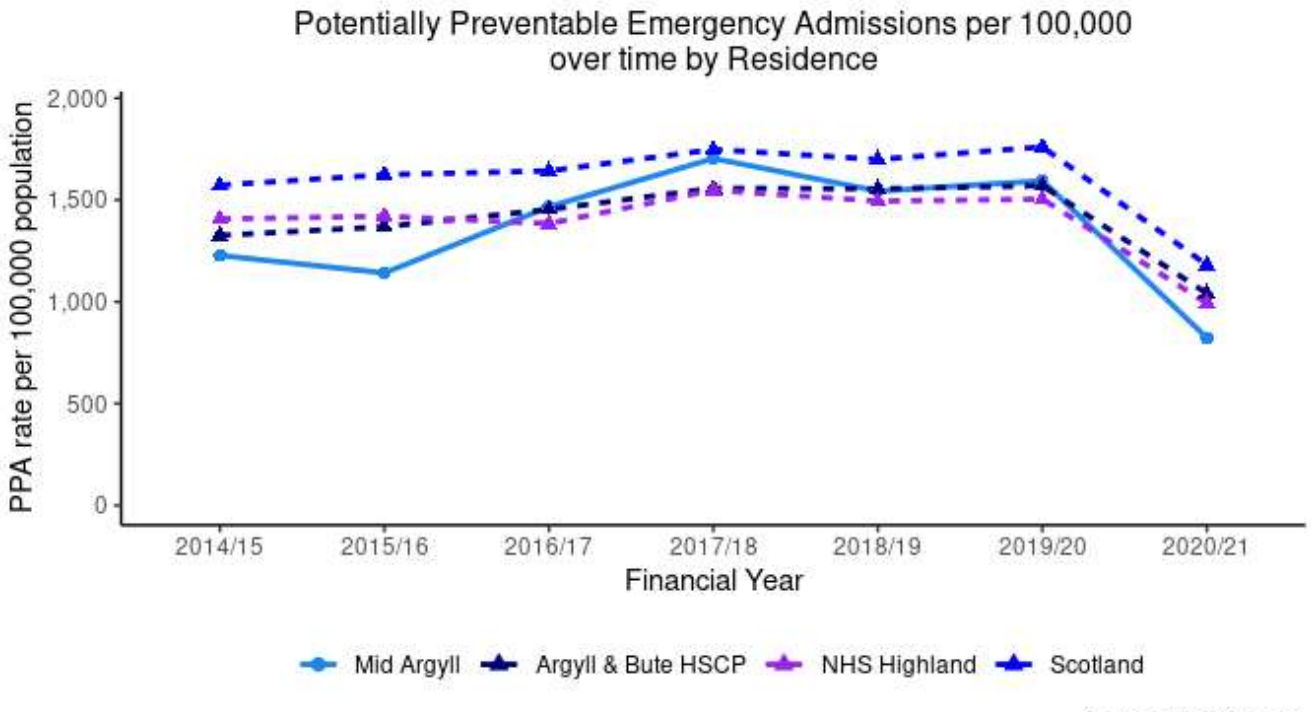
Information on which conditions are counted as PPAs is available in Appendix 3 in the accompanying summary document.

Figure 37: PPAs by age group



Source: PHS SMR01

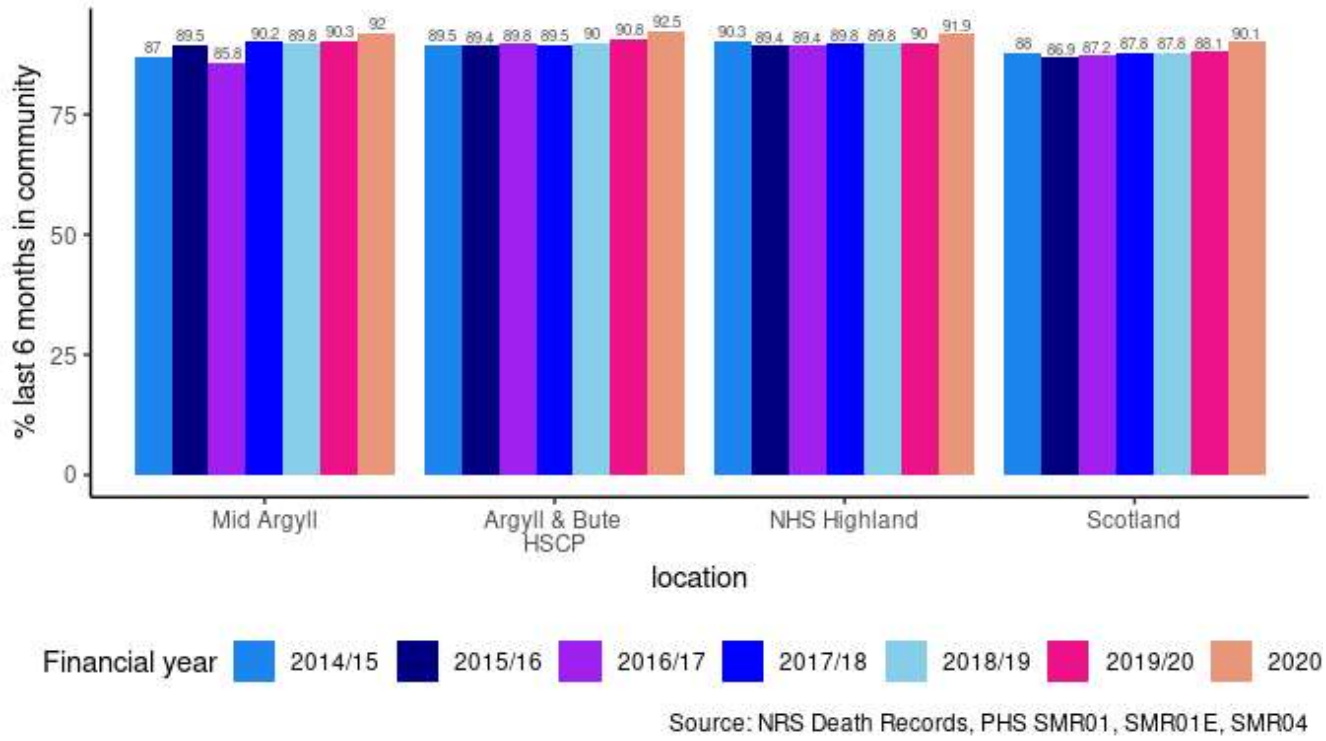
Figure 38: PPAs by geographical area



Source: PHS SMR01

% Last 6 months in a Community Setting

Figure 39: Last 6 months in a community setting by geographical area



Footnotes

1. Population projections are not currently provided by NRS at the locality level. To explore how the population in Mid Argyll is expected to change in the future, the percent changes in population projection to 2025 for Argyll and Bute by age group and gender were calculated from the NRS Local Authority Population Projections. These percent changes were then applied to the Mid Argyll 2018 mid-year population estimates (also split by age group and gender) to obtain population projection estimates for Mid Argyll, based on the projections for the HSCP and the current population structure of the locality.
2. Care Home Data included in the Services Map and Table was sourced from the Care Inspectorate. GP Practice data from October 2021, and Hospital and A&E data was sourced from Public Health Scotland Open Data. Only services that are within the physical boundary of the HSCP or Locality are included in the map and table, so there may be services outside Argyll and Bute which people may use but are not shown.
3. The data used in General Health and Behavioural Factors sections (except for long-term conditions) of this locality profile are taken from ScotPHO. There may be more recent data available for the indicators elsewhere.
4. Data taken from ScotPHO is often reported using the European Age-Sex Standardised Rate per 100,000. This allows for comparisons across different areas to be made. For more information on how these rates are calculated, please refer to www.isdscotland.org/Products-and-Services/GPD-Support/Population/Standard-Populations/
5. Physical long-term conditions data comes from the Source Linkage Files, and the conditions are identified using ICD-9 and ICD-10 codes in the diagnosis fields. Please note that the Source Linkage Files data only contains information on people who have had contact with the NHS through either inpatient admissions, outpatient attendances, daycase attendances, A&E attendances or through prescribed items, the data does not show all service users in Scotland who have been diagnosed with an LTC as not all of these individuals will have used these services. Also note that LTC rates are based on an adjusted population indicator in the Source Linkage Files so that population sizes are closer to the official estimates.
6. The 2020 COVID-19 pandemic will have had an effect on the most recent data available. A dashboard has been created by PHS which show the wider impacts of COVID-19 over many areas. You can access this here: https://scotland.shinyapps.io/phs-covid-wider-impact/

Locality Profile

Kintyre Locality

October 2021

Table of Contents

Notes for this profile:

- All years shown are calendar years unless otherwise specified.
- Upper and lower 95% confidence intervals are shown throughout this document where available. In charts, these are displayed as shaded areas either side of trend lines, or as black error bars in bar charts. Confidence intervals show the range of possible values and a certainty that the true value falls within them.
- Definitions for the indicators shown are available in Appendix 1 in the accompanying summary document.
- Any zero figures for some indicators will indicate either suppression of small data or a complete lack of data available for this locality
- Data should be interpreted with caution, particularly for areas with relatively small population sizes where indicator data is expected, by chance alone, to have higher variation than in areas of larger population size. Note that differences between areas can relate to multiple factors including, for example, underlying rates of illness, rates of diagnosis and local differences in practice e.g. in data recording.
-

Demographics

Summary:

For the most recent time periods available, Kintyre Locality had:

- A total population of **7,375** people, where **49%** were male, and **28%** were aged over 65.
- **0%** of people lived in the least deprived SIMD quintile, and **15%** lived in the most deprived quintile.

Population

In 2020, the total population of Kintyre locality was 7,375. The graph below shows the population distribution of the locality.

Figure 1: Population breakdown in Kintyre.

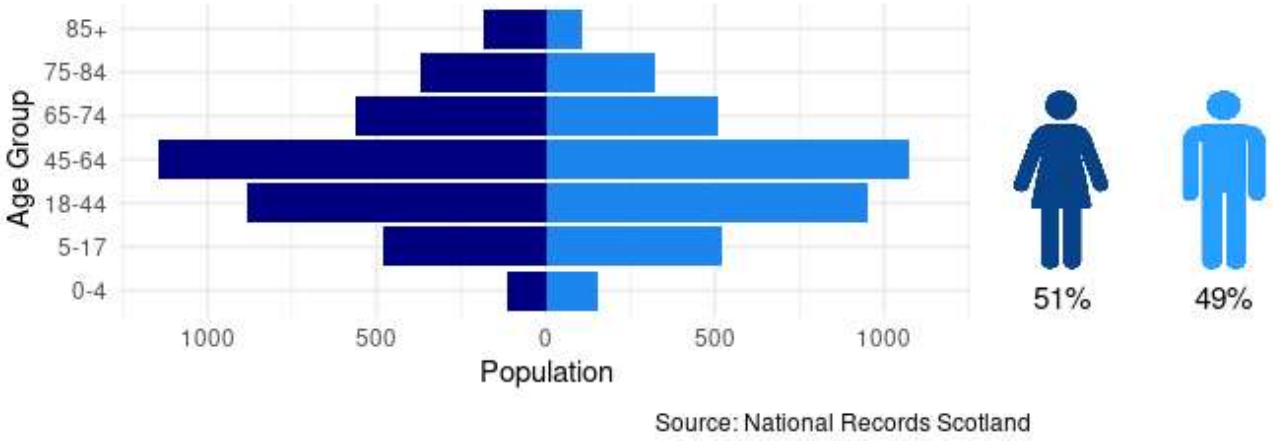


Figure 2 shows the historical population of Kintyre, along with the NRS population projections. The population has been falling. The population in Kintyre is estimated to decrease by 2.8% from 2020 to 2025 *Please see the footnotes for more information on how the population projections were calculated*[1].

Figure 2: Population time trend and projection.

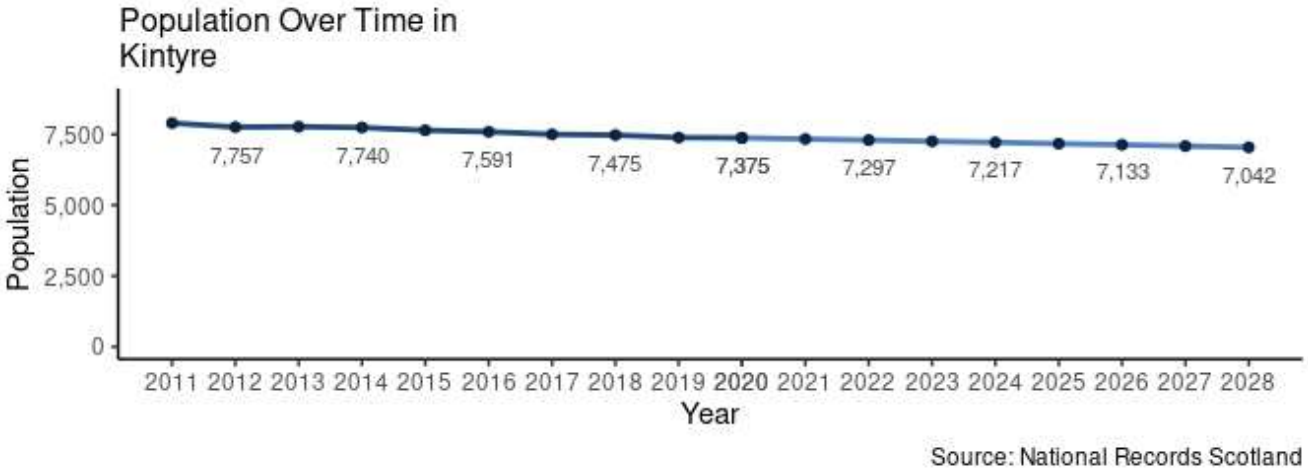
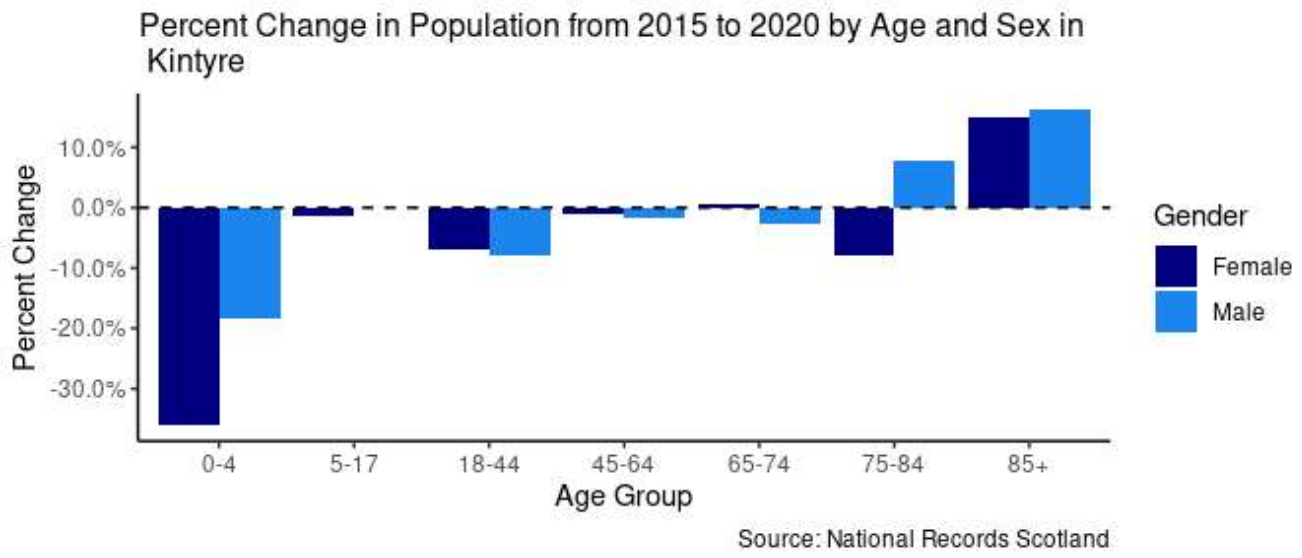


Figure 3 shows how population structure has changed between 2015 and 2020.

Figure 3: Change in population structure over the last five years.



Deprivation

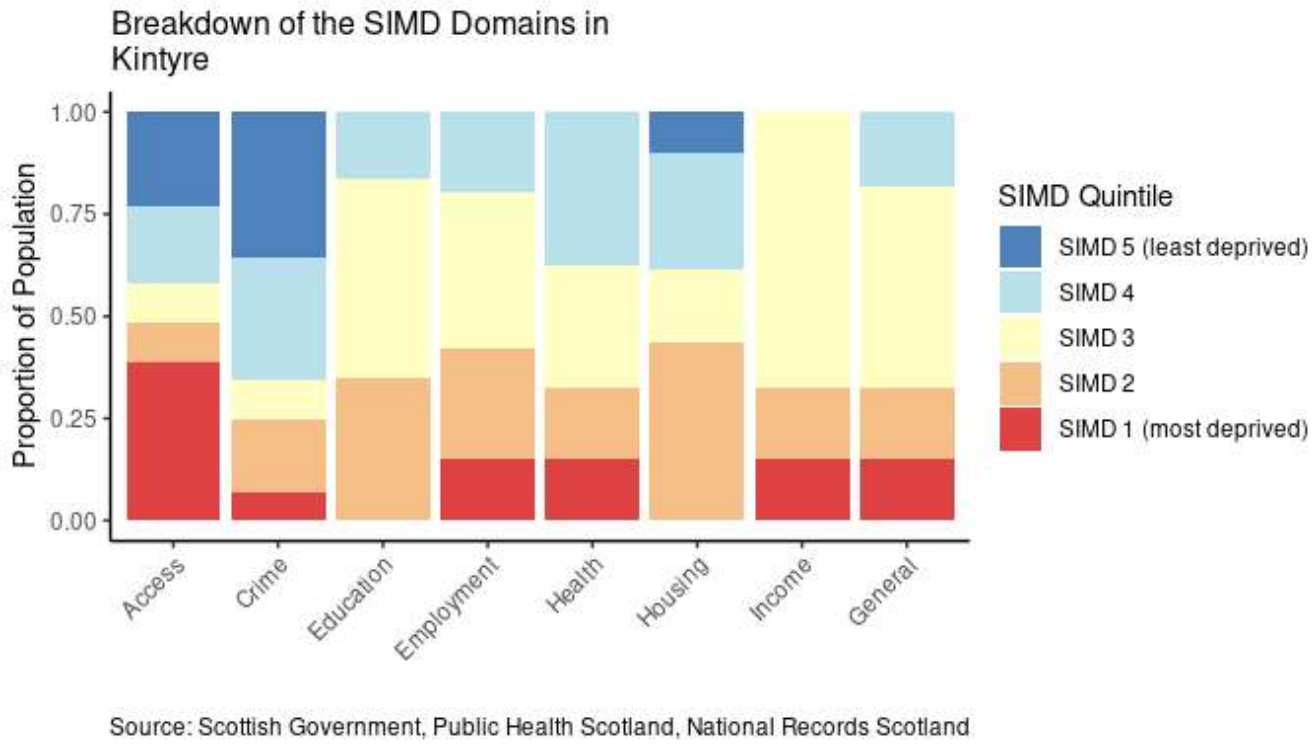
The following section explores the deprivation structure of Kintyre through the Scottish Index of Multiple Deprivation (SIMD). The SIMD ranks all datazones in Scotland by a number of factors; Access, Crime, Education, Employment, Health, Housing and Income. Based on these ranks, each datazone is then given an overall deprivation rank, which is used to split datazones into Deprivation Quintiles (Quintile 1 being the most deprived, and Quintile 5 the least). The most recent SIMD ranking was carried out in 2020. This section mainly focuses on the SIMD 2020 classifications, however the 2016 classifications are used to assess how deprivation has changed in Kintyre when compared to the rest of Scotland.

Of the 2020 population in Kintyre, **15%** live in the most deprived SIMD Quintile, and **0%** live in the least deprived SIMD Quintile. The following table details the percent of the population living in the 2016 SIMD Quintiles, the percent living in the 2020 SIMD Quintiles, and their difference for comparison.

Table 1: Percentage population living in the 2016 and 2020 SIMD Datazone Quintiles

Quintile	Percent of Pop (2016)	Percent of Pop (2020)	Difference
SIMD 1	15.8%	14.9%	-0.9%
SIMD 2	16.7%	17.6%	0.9%
SIMD 3	58.8%	49.2%	-9.7%
SIMD 4	8.7%	18.3%	9.6%
SIMD 5	0.0%	0.0%	0.0%

Figure 4: Proportion of the population that reside in each 2020 SIMD quintile by domain.



Source: Scottish Government, Public Health Scotland, National Records Scotland

Households

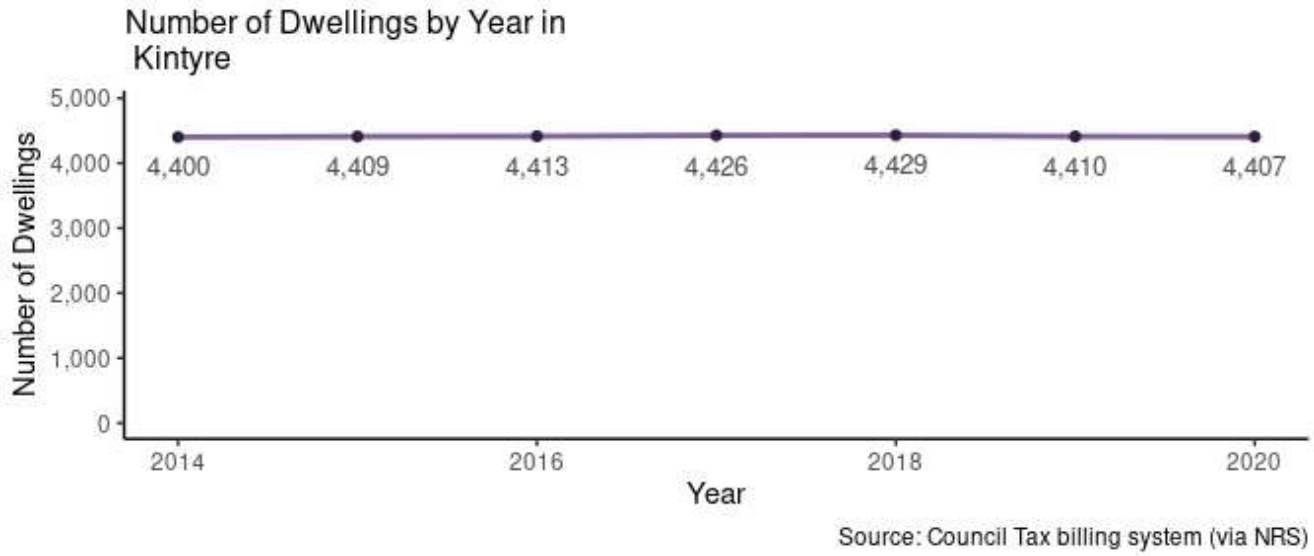
Summary:

For the most recent time periods available, Kintyre Locality had:

- **4,407** dwellings, of which: **89%** were occupied and **5.1%** were second homes.
- **35%** of dwellers received a single occupant council tax discount, and **1.6%** were exempt from council tax entirely.
- **69%** of houses were within council tax bands A to C, and **6.2%** were in bands F to H.

The graph below shows the number of dwellings in Kintyre from 2014 to 2020.

Figure 5: Number of dwellings time trend.



Of the total number of dwellings in 2020, 35% (1,532 households) were occupied by an individual receiving a single occupant council tax discount. Furthermore, 1.6% (69 households) were occupied and exempt from council tax.

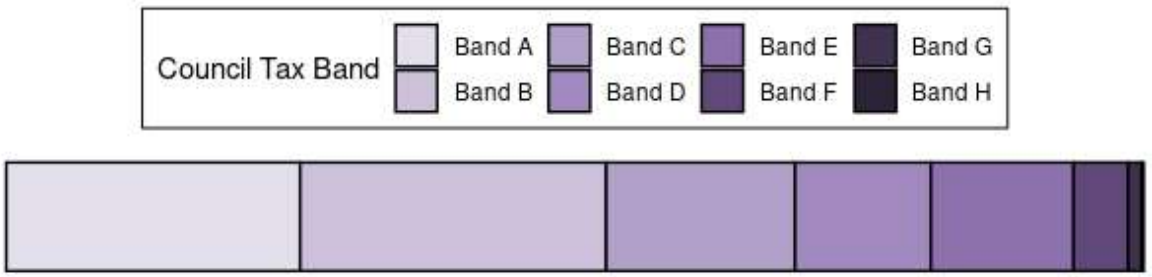
There were 226 dwellings classed as a second home in 2020, these dwellings made up 5.1% of the households in Kintyre.

Table 2: Breakdown of dwelling types by year for Kintyre locality.

Year	Total Dwellings	Occupied Dwellings	Vacant Dwellings	Single Occupant Tax Discount	Council Tax Exempt Dwellings	Second Homes
2014	4,400	3,885	274	1,561	55	241
2015	4,409	3,870	303	1,532	52	235
2016	4,413	3,873	309	1,523	55	231
2017	4,426	3,901	295	1,519	52	230
2018	4,429	3,904	294	1,540	61	231
2019	4,410	3,892	285	1,525	69	233
2020	4,407	3,916	265	1,532	69	226

The proportion of households within each council tax band are displayed in the chart below, figures are shown in Table 3.

Figure 6: Breakdown of households by council tax band for Kintyre in 2020.



Source: Scottish Assessors' Association (via NRS)

Table 3: Percentage of households by council tax band for Kintyre in 2020.

Tax Band	A	B	C	D	E	F	G	H
Percent of households	26%	27%	17%	12%	13%	4.8%	1.2%	0.2%

General Health

Summary:

For the most recent time periods available[3], Kintyre Locality had:

- **An average life expectancy of 77.1 years for males and 81.5 years for females.**
- **A death rate for ages 15 to 44 of 151 deaths per 100,000 age-sex standardised population[4]**
- **26%** of the locality's population with at least one long-term physical health condition.
- A cancer registration rate of **642** registrations per 100,000 age-sex standardised population[4]
- **21.42%** of the population being prescribed medication for anxiety, depression, or psychosis.

Life Expectancy

In the latest time period available from 2016-2020 (5 year aggregate), the average life expectancy in Kintyre locality was 77.1 years old for men, and 81.5 years old for women. A time trend since 2013-2017 can be seen in figure 8.

Figure 8: Average life expectancy in men and women over time.

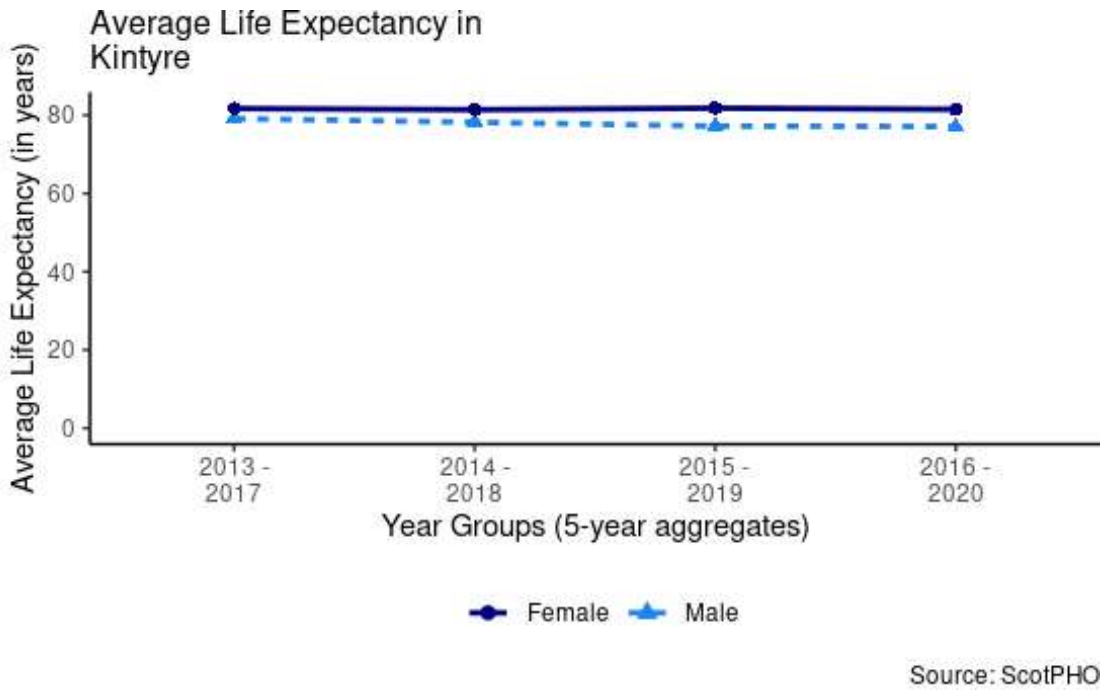


Table 5 provides the average life expectancy for men and women in different areas for the latest time period available. Please note that these are 5 year aggregates for the locality from 2016-2020, but 3 year aggregates from 2018-2020 at partnership, Health Board, and Scotland level.

Table 5: Average life expectancy in years for the latest time periods (2016-2020 aggregated years for the locality; 2018-2020 aggregated years for other areas).

	Locality	Partnership	Health Board	Scotland
	81.5	81.6	81.8	81
	77.1	78	77.6	76.8

Where Locality = Kintyre, Partnership = Argyll and Bute HSCP, Health Board = NHS Highland.

Deaths, aged 15-44

The following chart shows a trend of death rates among 15-44 year olds per 100,000 age-sex standardised population[4] by area (i.e. Early mortality rate per 100,000). In the most recent aggregate time period available (from 2018-2020), the mortality rate in Kintyre locality was **151** deaths per 100,000 population. Figure 10 then provides comparisons of deaths for all localities in Argyll and Bute HSCP, for the two latest time aggregates available.

Figure 9: Deaths aged 15-44 years by geographical area and over time.

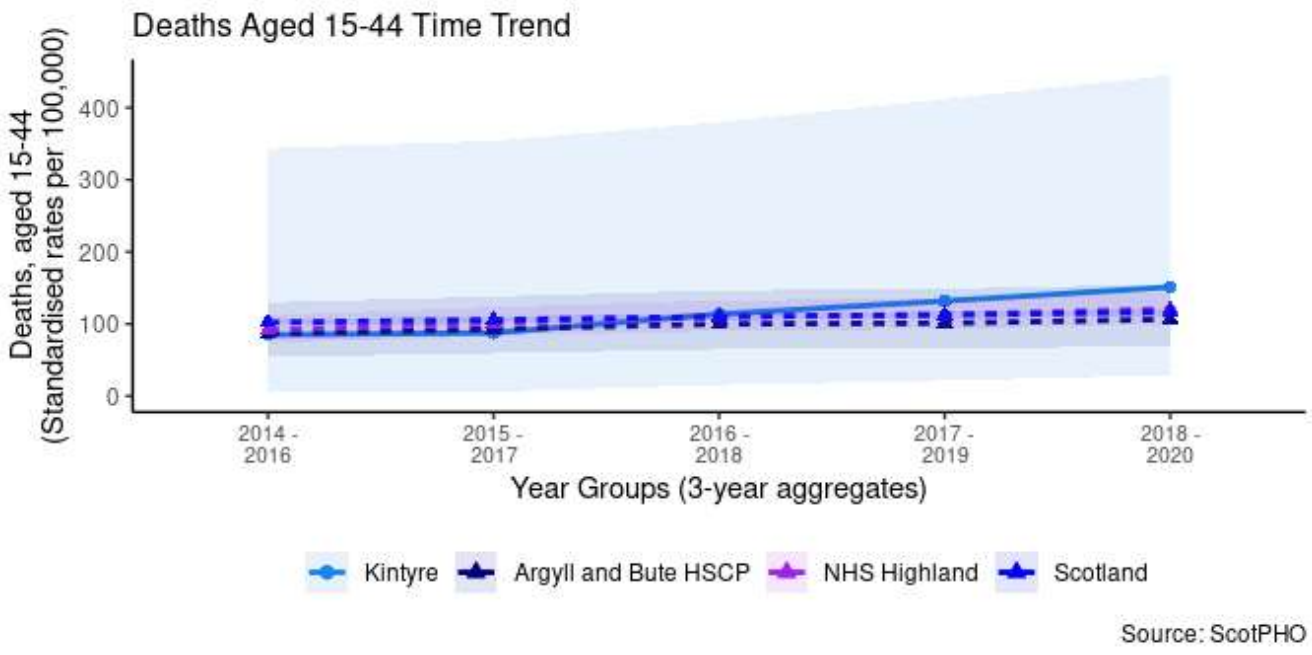
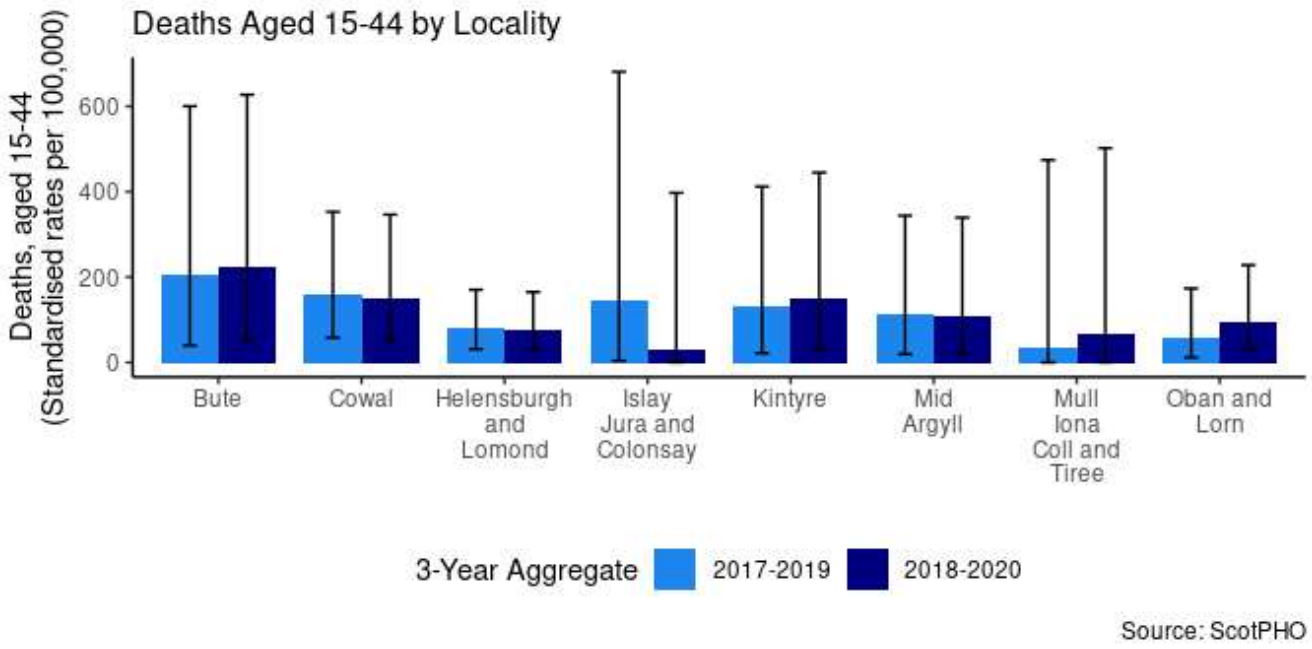
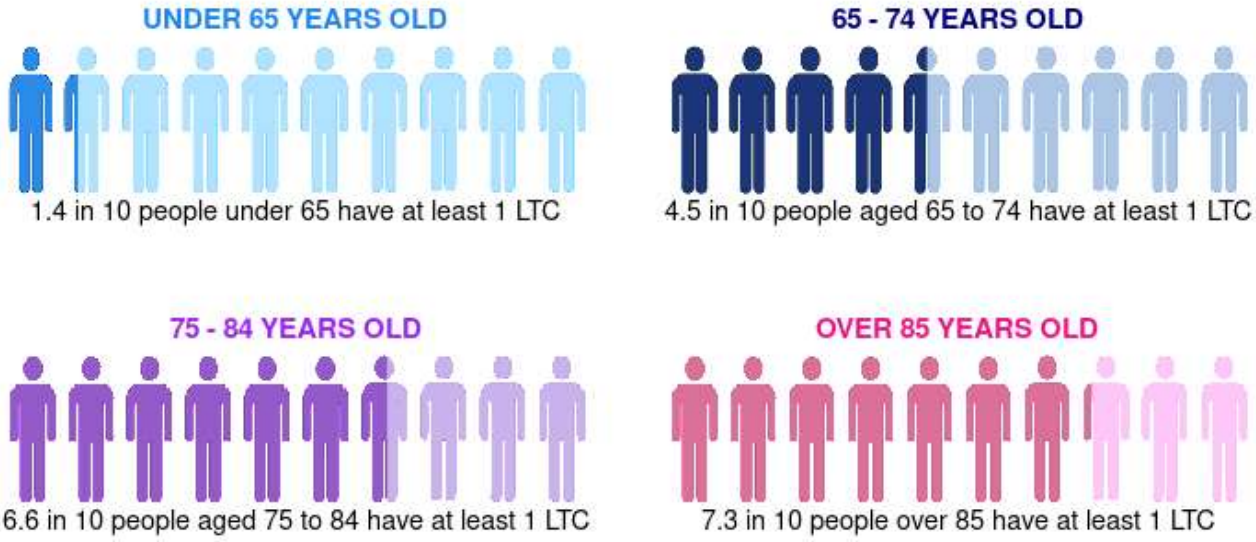


Figure 10: Deaths at ages 15-44 in Argyll and Bute HSCP localities.



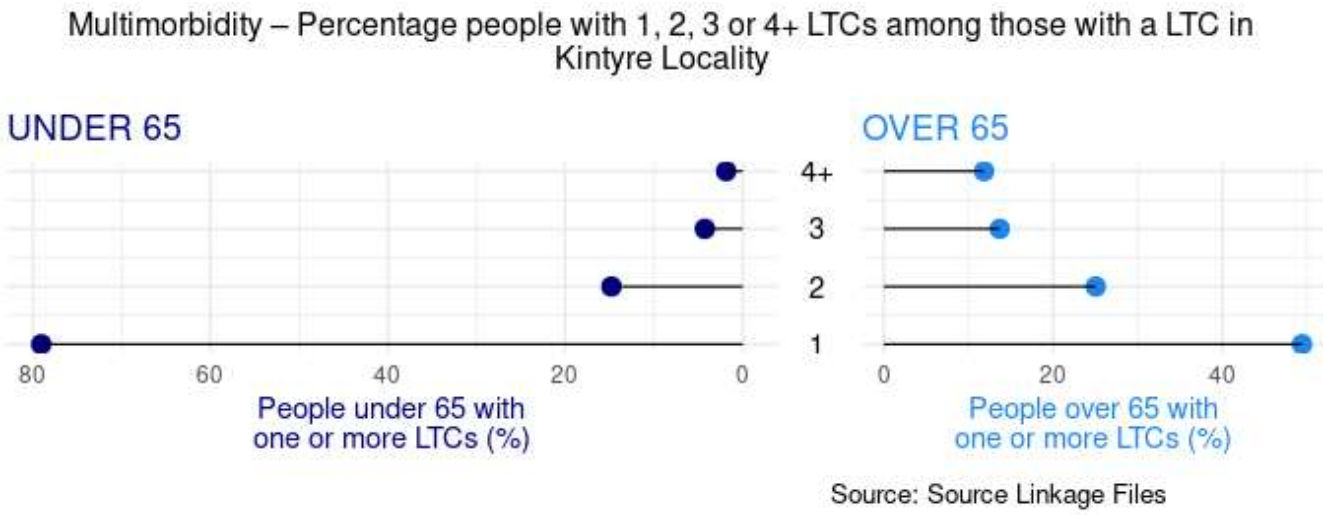
Long-Term Physical Health Conditions and Multimorbidity

In the financial year 2020/21, in Kintyre Locality, **26%** of the total population had at least one physical long-term condition (LTC). These include: cardiovascular, neurodegenerative, and respiratory conditions, as well as other organ conditions (namely liver disease and renal failure), arthritis, cancer, diabetes, and epilepsy. *Please see footnotes for information and caveats on identifying LTCs.*[5]



The co-occurrence of two or more conditions, known as multimorbidity, is broken down in figure 11, distinguishing between age groups. Note that this chart *excludes* the population in the locality who do not have any physical long-term conditions. Figure 13 therefore shows that among the people who have a LTC, **21**% of those under the age of 65 have more than one, compared to **51**% of those aged over 65.

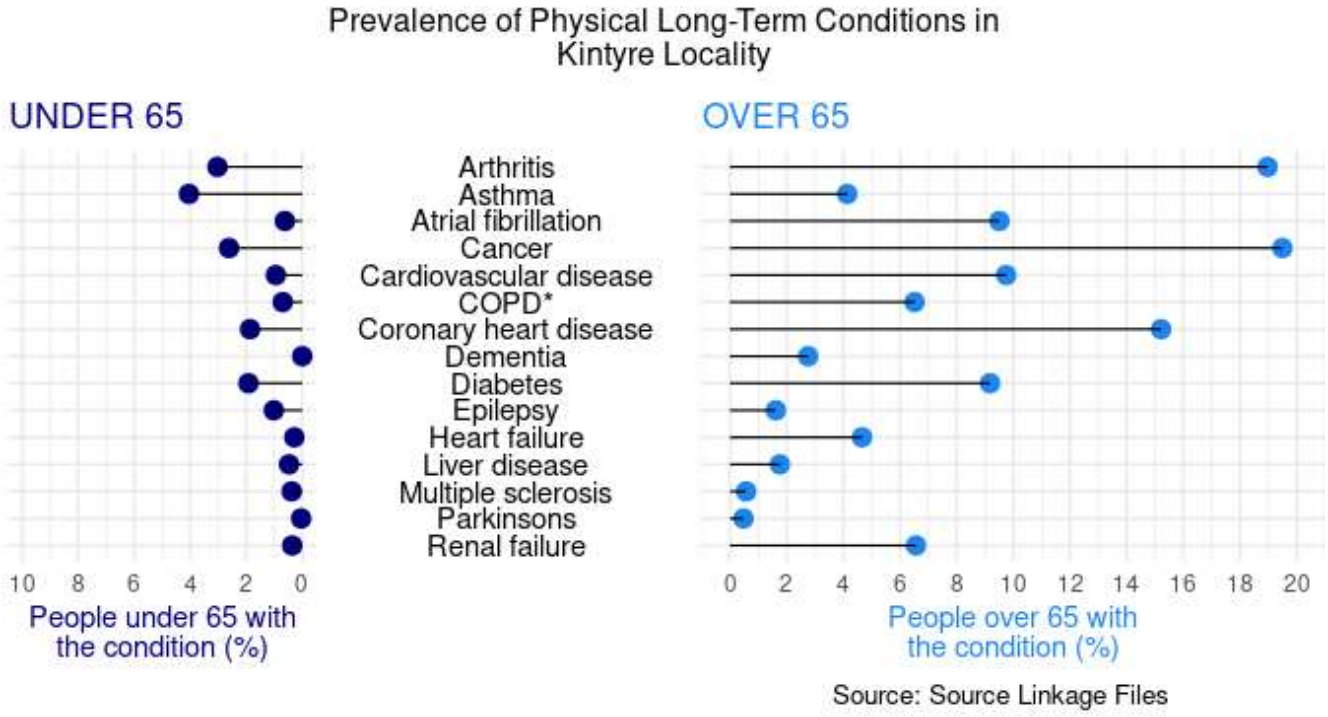
Figure 11: Multimorbidity of physical long-term conditions by age group in 2020/21.



Most common physical Long-Term Conditions (LTCs)

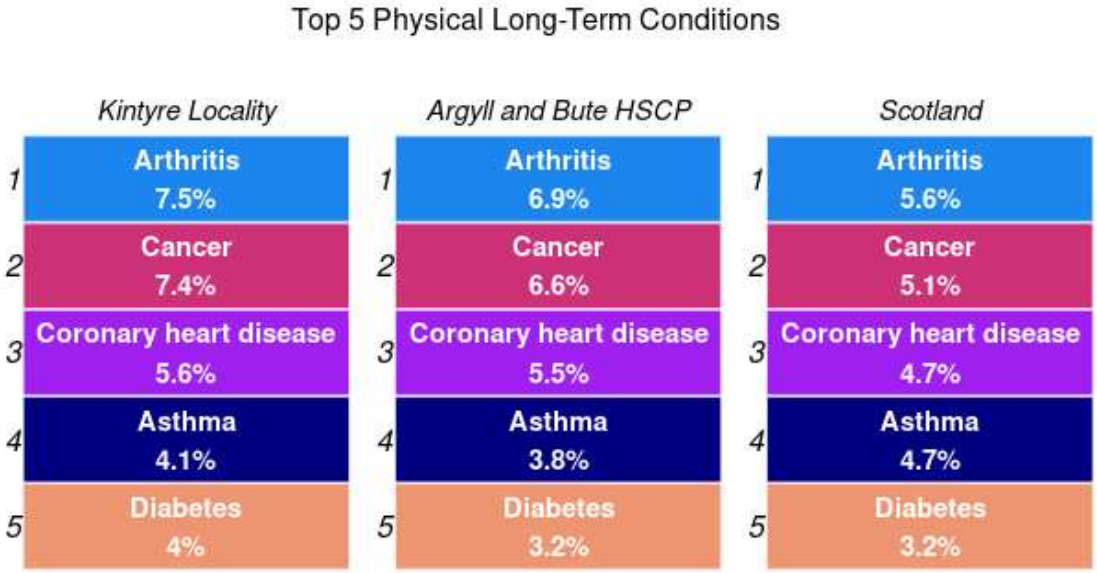
Below is a breakdown of the physical LTCs, for the financial year 2020/21. Figure 12 shows the prevalence of different LTCs in each age group in Kintyre locality, and Table 6 illustrates the top 5 physical LTCs across all ages at locality, partnership, and Scotland level.

Figure 12: Percentage people with each physical LTC, split by age group.



COPD: Chronic Obstructive Pulmonary Disease

Table 6: Prevalence of the five most common physical LTCs as a percentage of the population across geographical areas (where 1 = most prevalent).



Cancer Registrations

For the period 2017-2019, there were 60 new cancer registrations per year on average (**642** registrations per 100,000 age-sex standardised population) in Kintyre locality. This is a **9.1%** decrease in cancer registrations rate from the previous aggregate period 2016-2018. Figure 13 shows changes over time since 2014-2016, and Figure 14 compares the rates of localities in Argyll and Bute HSCP for the two latest available time periods.

Figure 13: Cancer registration rate over time and by geographical area.

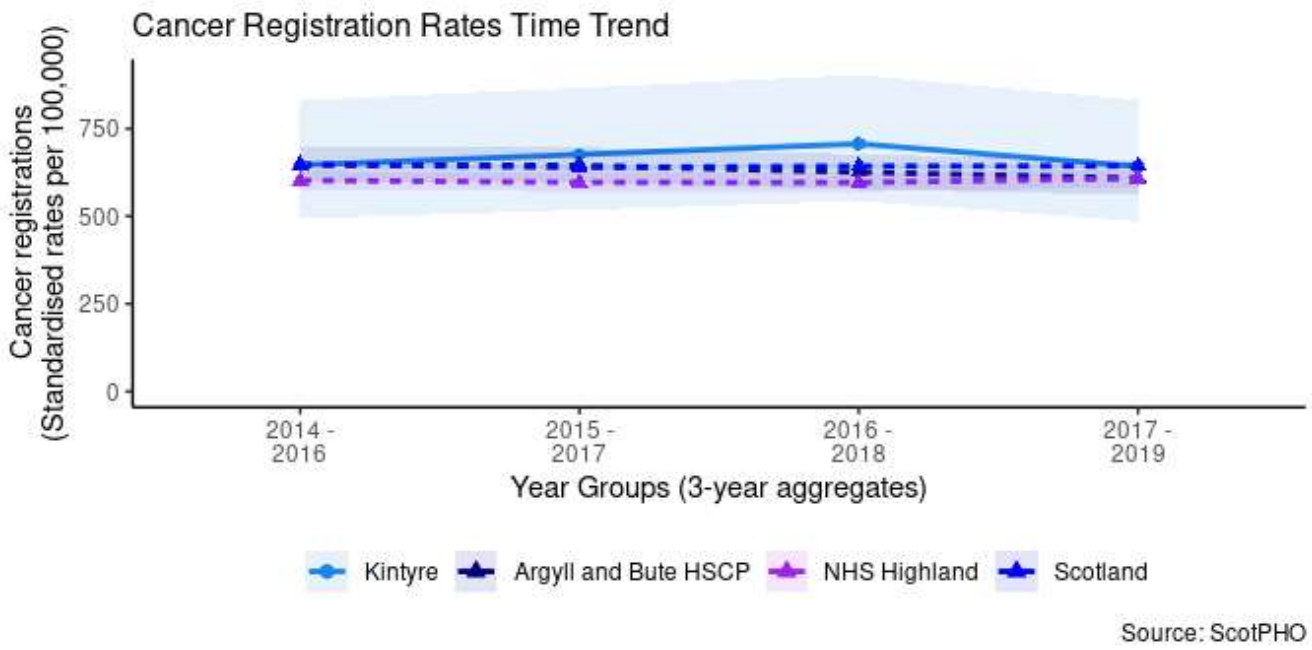
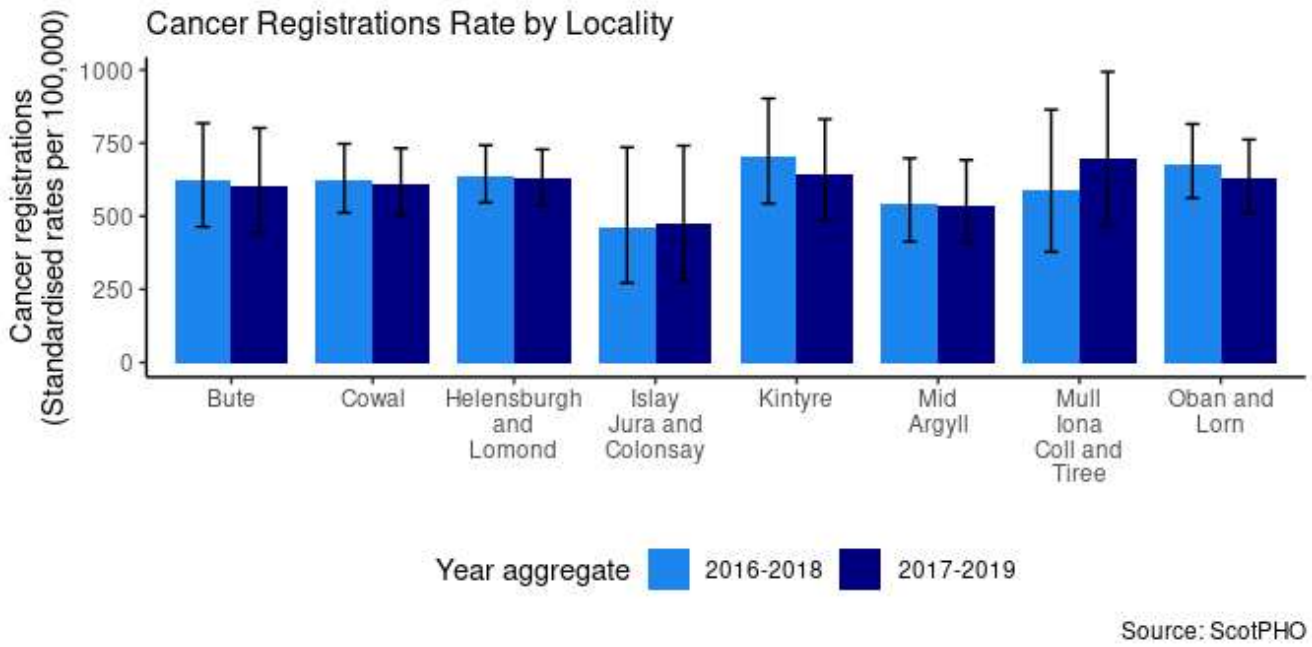


Figure 14: Cancer registration rates in Argyll and Bute HSCP localities.



Anxiety, Depression, and Psychosis Prescriptions

In the 2019/20 financial year, 21.42% of people were prescribed medication for anxiety, depression, or psychosis (ADP) in Kintyre Locality. This is a 8% increase from the previous financial year. Differences over time and between areas may relate to multiple factors, only one of which is underlying disease. Note that data are based on main original licensed use for the prescriptions and some drugs included may be prescribed for other purposes.

Figure 15: Percentage population prescribed ADP medication in Argyll and Bute HSCP localities.

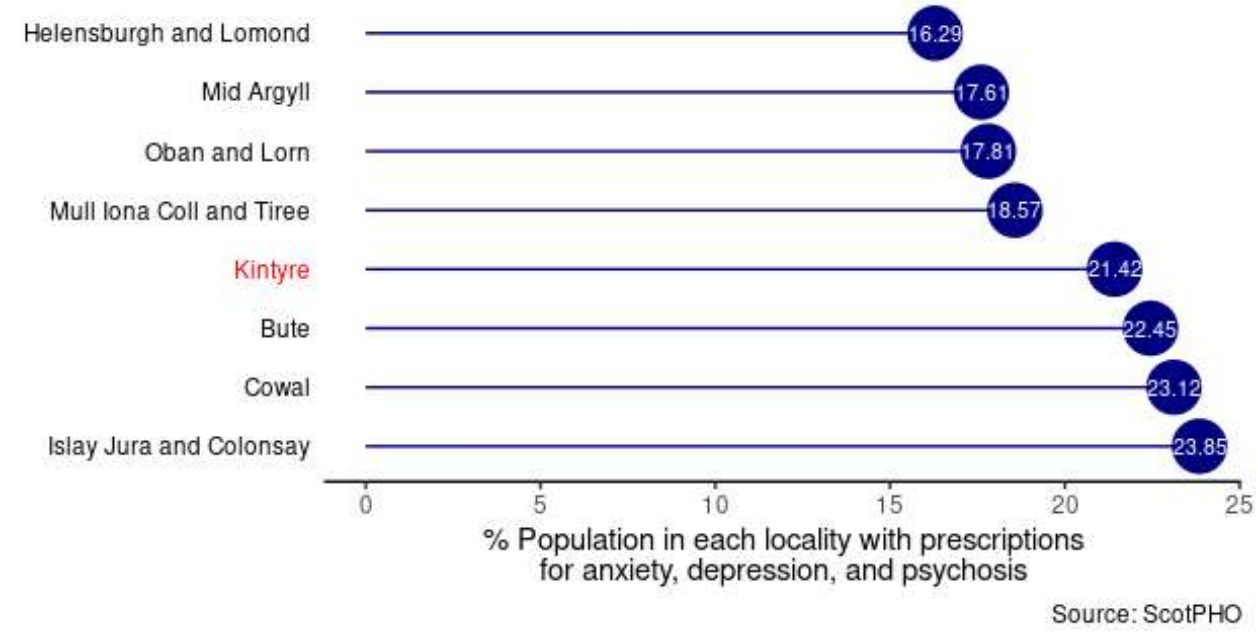
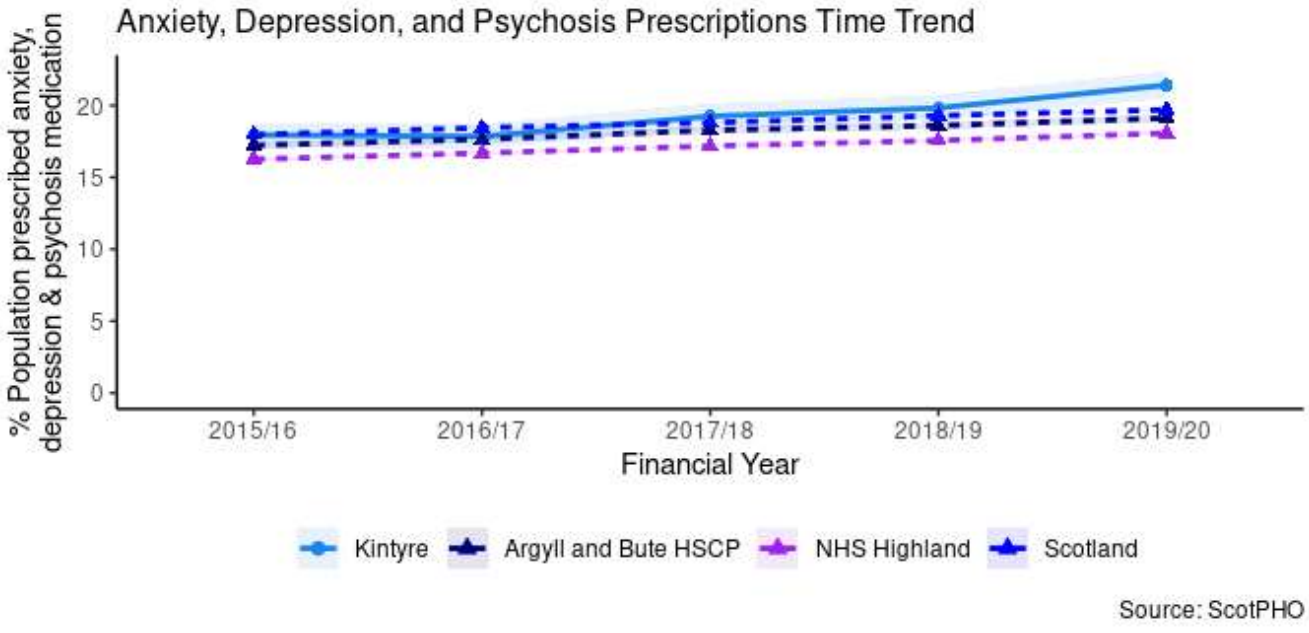


Figure 16: ADP prescriptions over time and by geographical area.



Behavioural Factors

Summary:

Mental and physical wellbeing has close ties with people's behaviours. Life circumstances including financial security, employment and location are interlinked with behavioural factors. This section provides data on drug-related hospital admissions, alcohol-related hospital admissions, alcohol-specific mortalities and bowel screening uptake, to give an overview of some behaviours known to be associated with health and wellbeing outcomes.

For the most recent time periods available[3], Kintyre had:

- **48** drug-related hospital admissions per 100,000 age-sex standardised population[4]. This is a lower rate of admissions than for Scotland (221).
- **590** alcohol-related hospital admissions per 100,000 age-sex standardised population[4].
- **34** alcohol-specific mortalities per 100,000 age-sex standardised population[4].
- a **63%** uptake of bowel cancer screening for the eligible population.

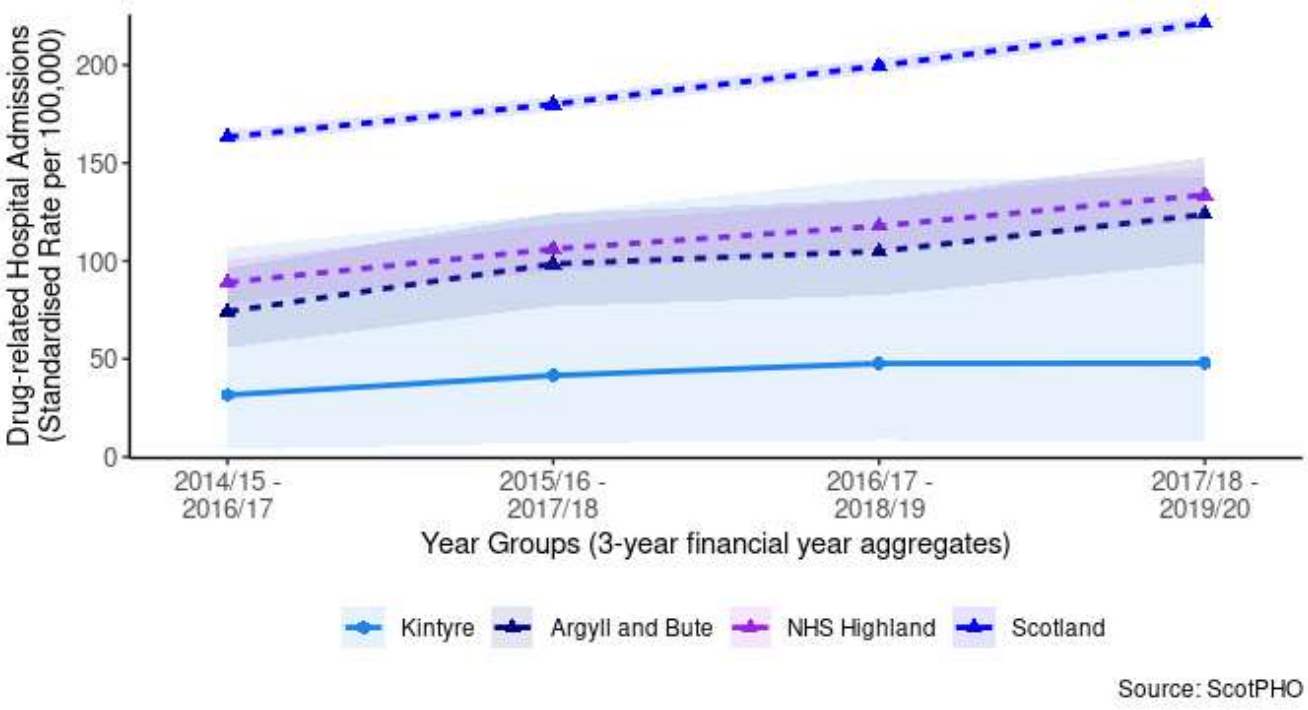
Drug-related Hospital Admissions

There were 48 drug-related hospital admissions per 100,000 age-sex standardised population[4] in Kintyre locality for the most recent time period available (3 year financial year aggregate for 2017/18 - 2019/20).

This is a 50% increase since 2014/15 - 2016/17 (3 financial year aggregates).

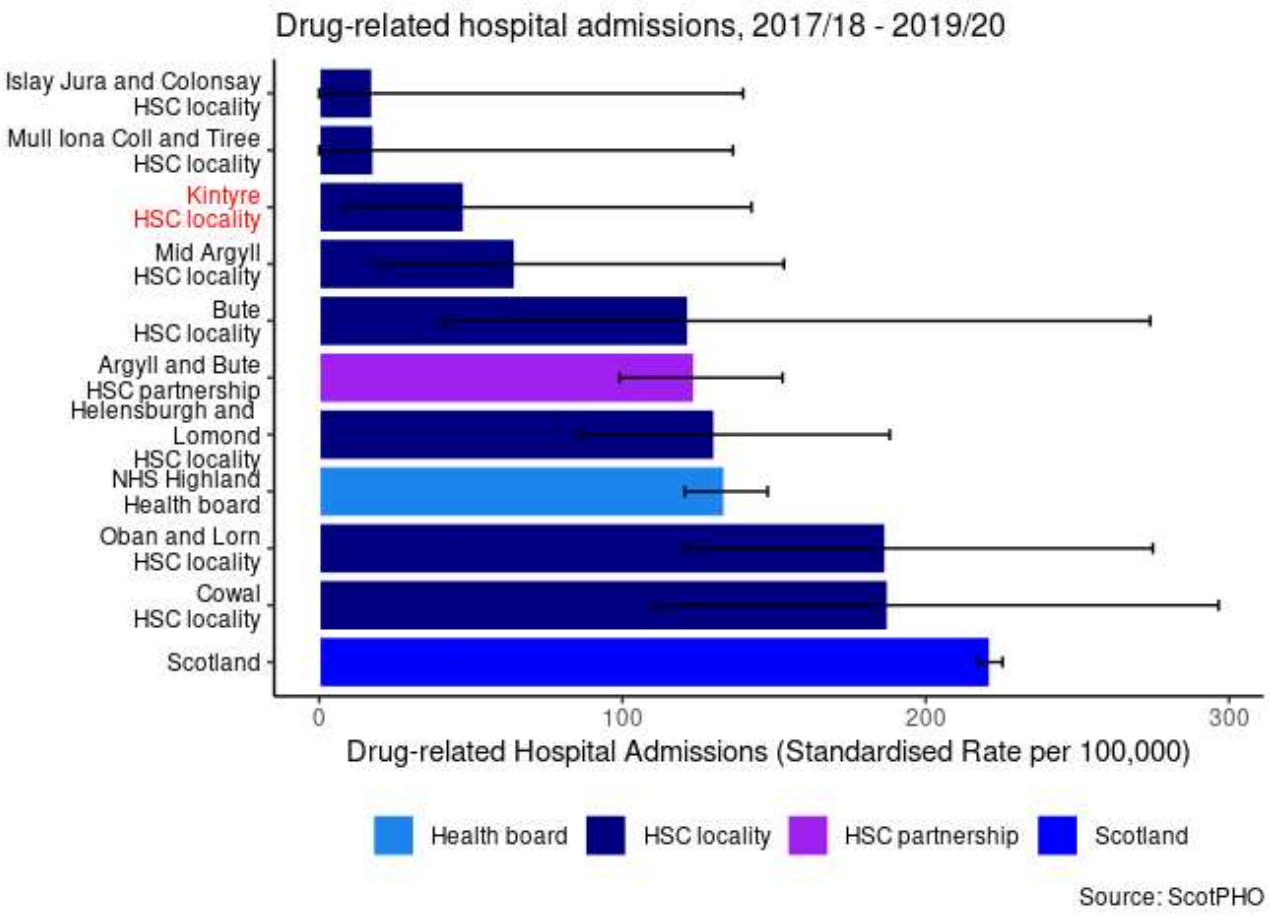
A trend of the change in drug-related hospital admissions for Kintyre locality compared with Scotland, Argyll and Bute HSCP and NHS Highland is shown in the chart below from 2014/15 - 2016/17 onwards.

Figure 17: Trend of Drug-related Hospital Admission Rates by geographical area.



A comparison of areas at the most recent time period (2017/18 - 2019/20 aggregated financial years) is available below. This shows Kintyre locality has a lower rate of admissions (48) than Argyll and Bute Partnership (124), and a lower rate of admissions than Scotland (221) overall.

Figure 18: Comparison of Drug-related Hospital Admission Rates for the period 2017/18 - 2019/20.

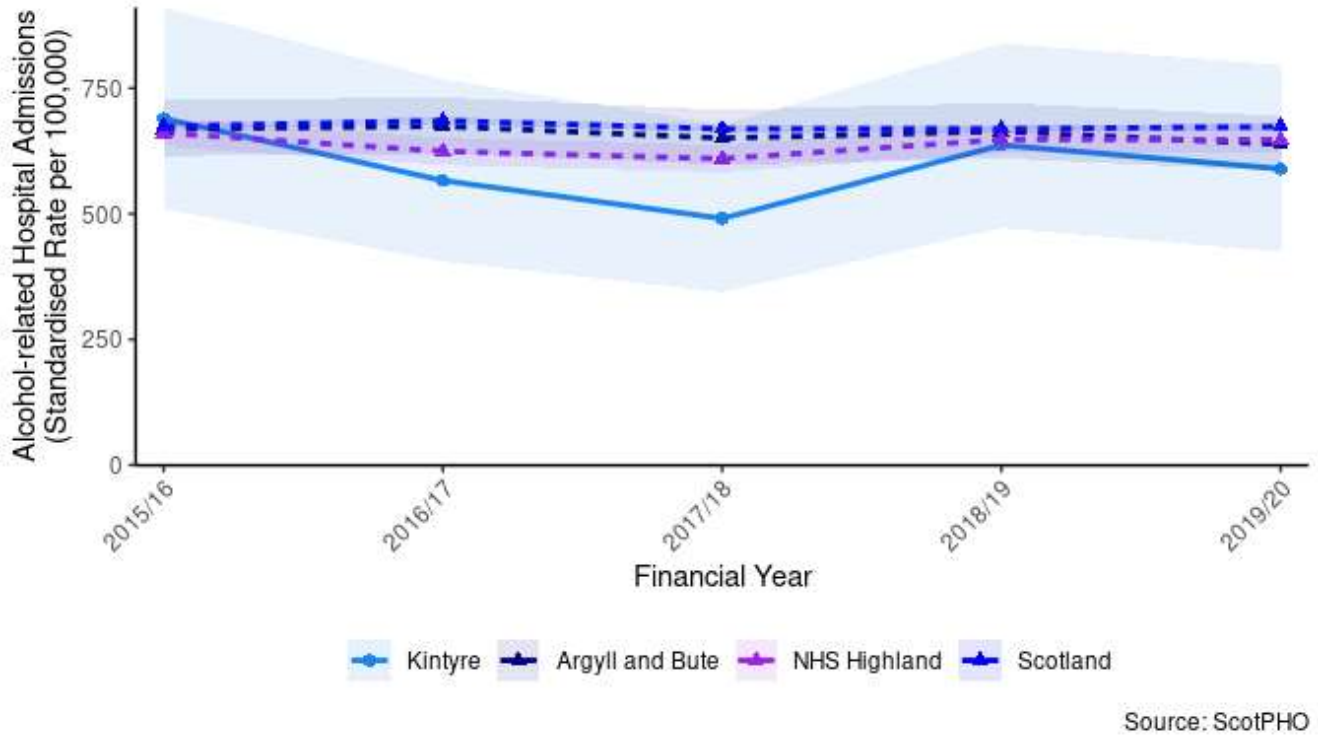


Alcohol-related Hospital Admissions

The 2019/20 alcohol-related admissions rate is 590 per 100,000 age-sex standardised population[4], which is a 14% decrease overall since 2015/16.

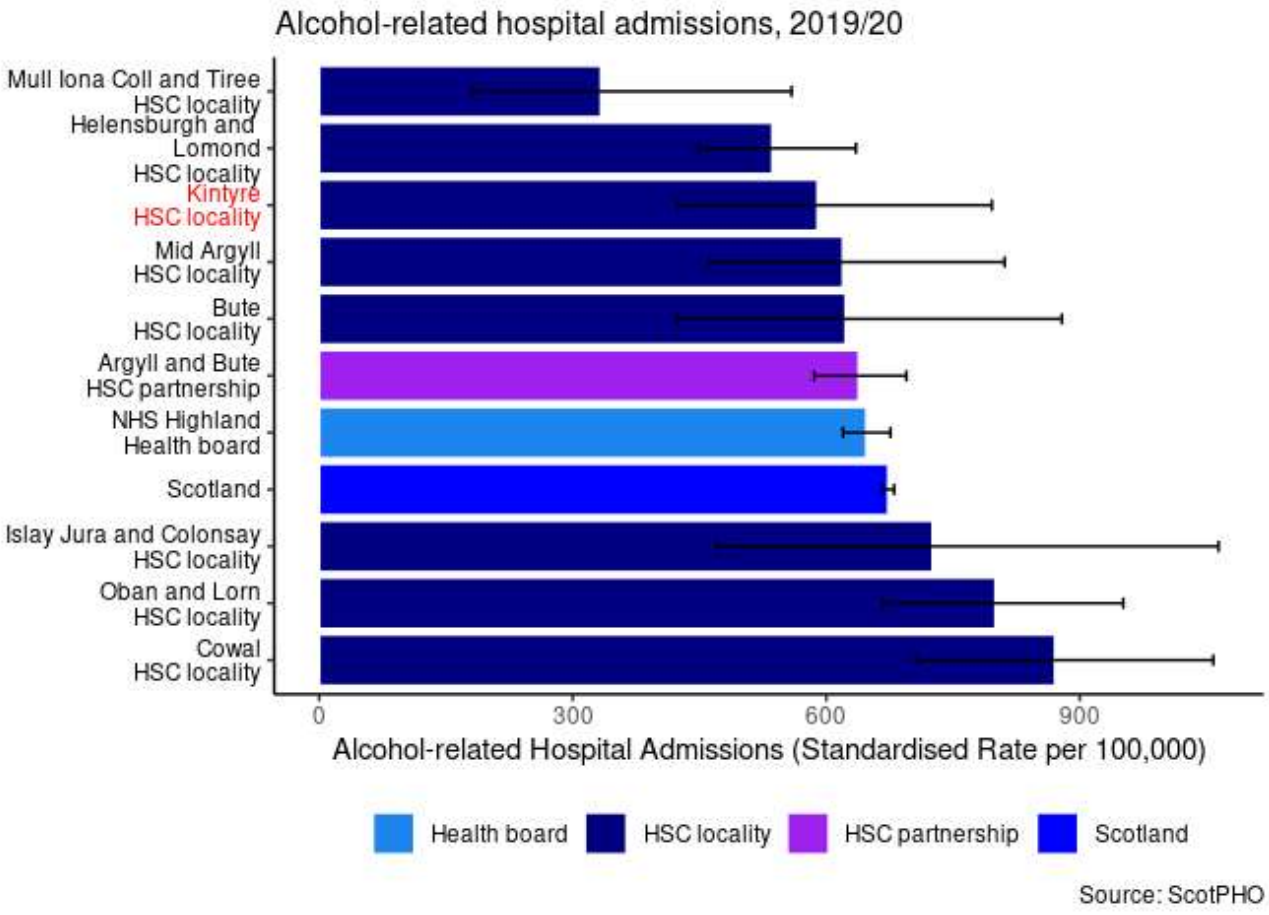
The chart below shows a trend of alcohol-related hospital admissions for Kintyre locality compared with Scotland, Argyll and Bute Partnership and NHS Highland from financial year 2015/16 to 2019/20.

Figure 19: Trend of Alcohol-related Hospital Admission Rates by geographical area.



Comparison across different areas for 2019/20 is shown in Figure 20. This shows that Kintyre locality had a lower alcohol-related hospital admissions rate (590) compared to Scotland (673).

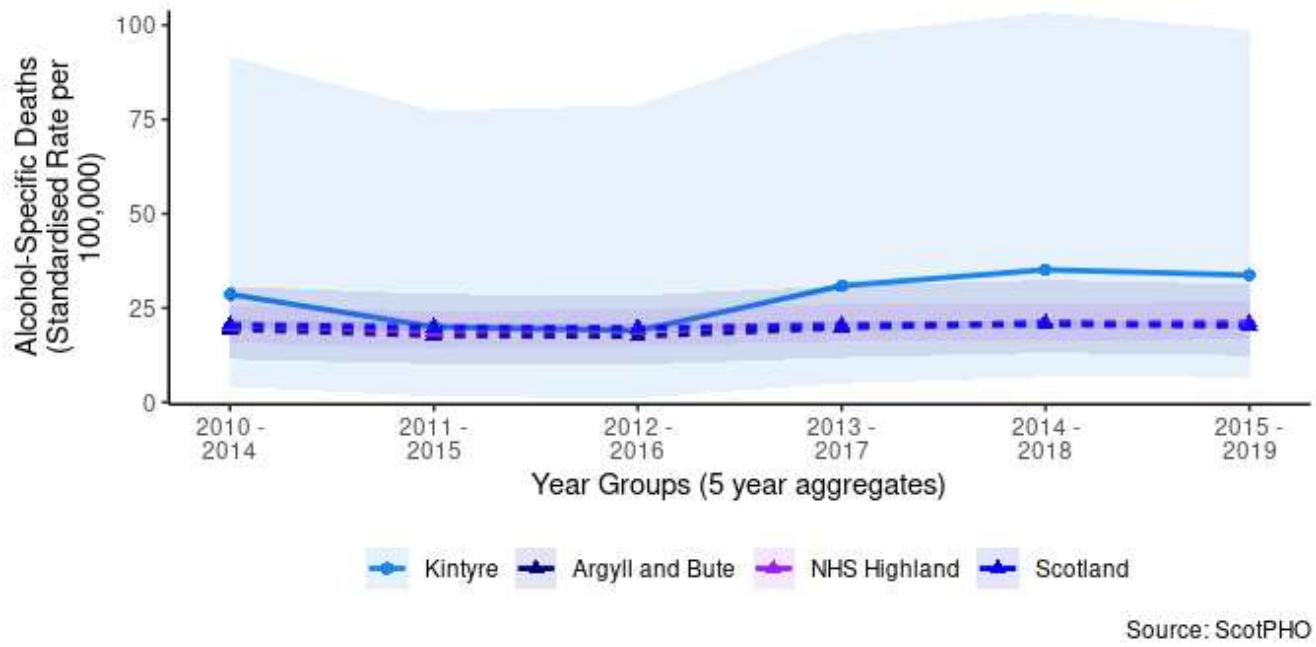
Figure 20: Comparison of Alcohol-related Hospital Admission Rates for 2019/20.



Alcohol-Specific Deaths

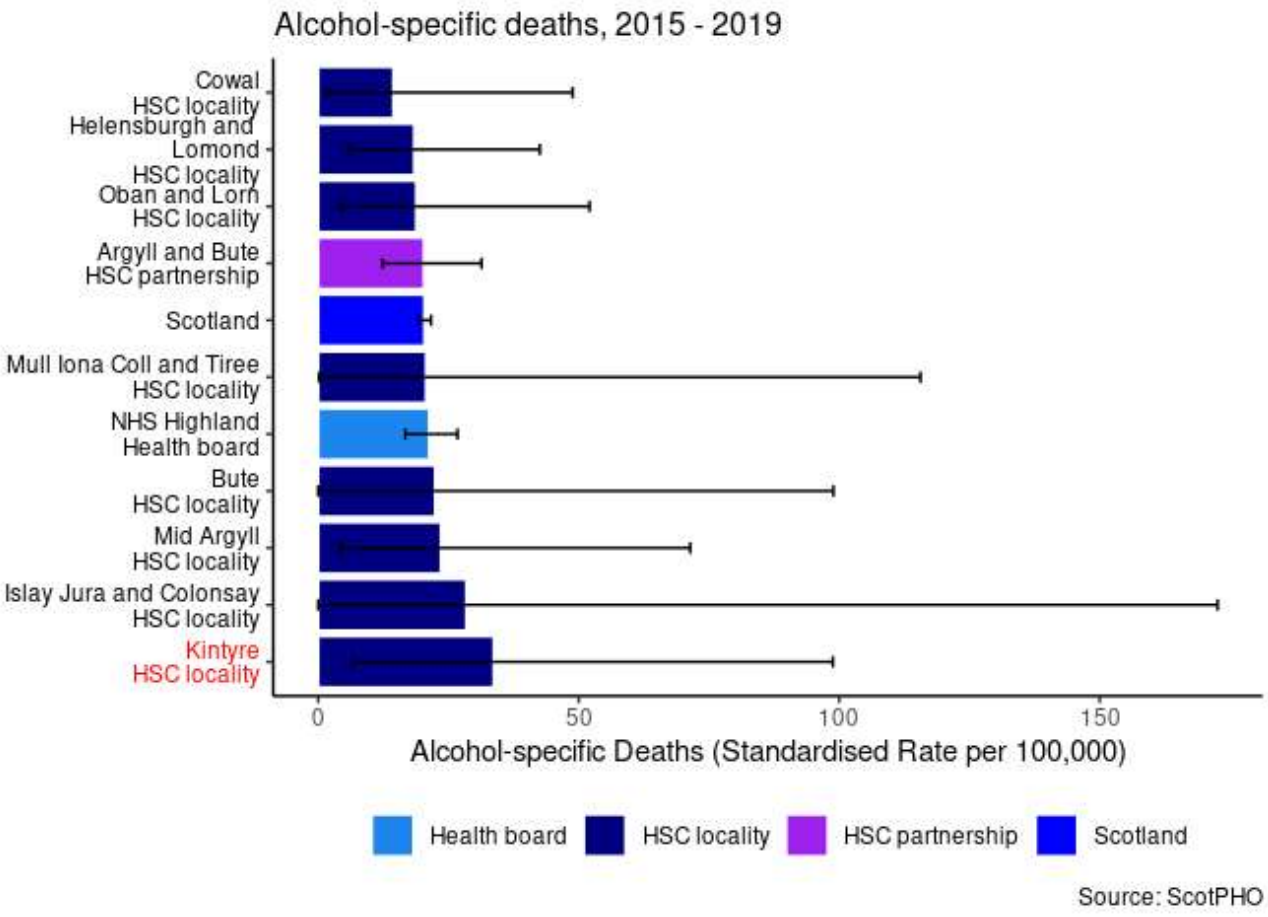
Data on alcohol-specific deaths is available as 5 year aggregates. The rate of alcohol-specific deaths is currently higher in Kintyre than the rate in 2010 - 2014 (18% change).

Figure 21: Trend of Alcohol-Specific Death Rates by geographical area.



A comparison across different areas illustrates that Kintyre locality has a higher alcohol-specific death rate compared to Scotland as a whole.

Figure 22: Comparison of Alcohol-related Death Rates for the period 2015 - 2019 (5 year aggregate).

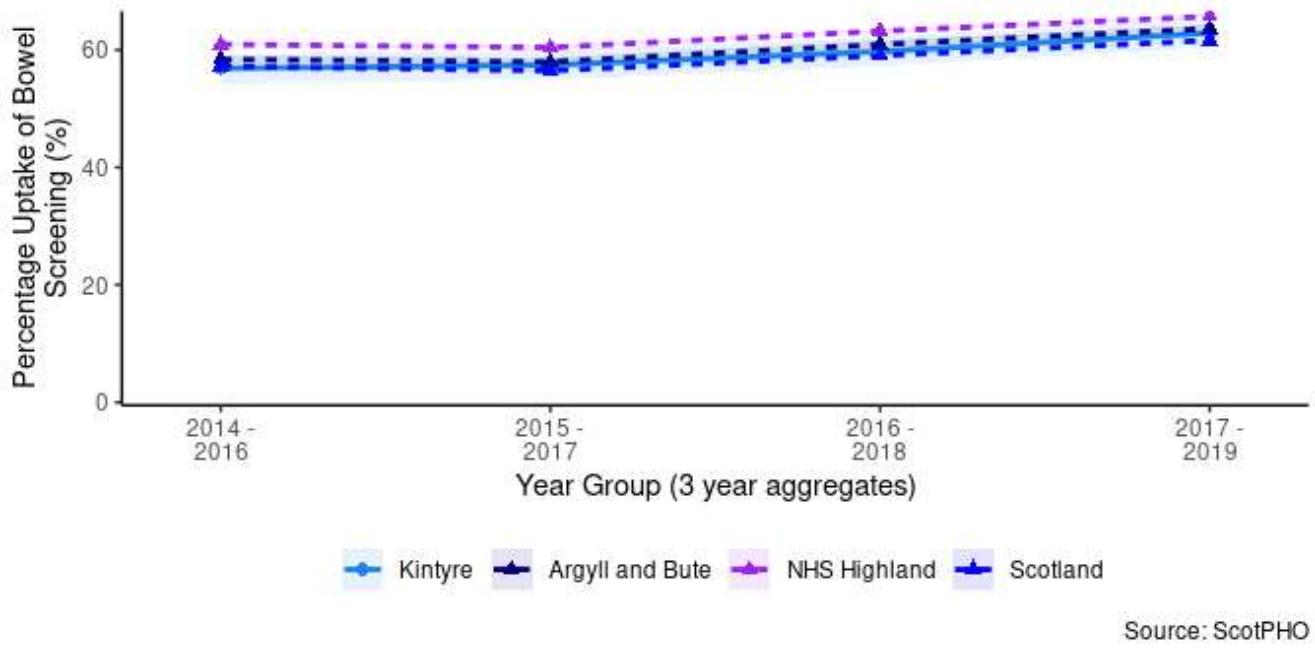


Bowel Screening Uptake

Bowel screening is offered every two years to eligible men and women aged between 50-74 years old. Eligible people are posted a test kit which is completed at home. Since 1st April 2013, those aged 75 and over can also self-refer and opt into screening.

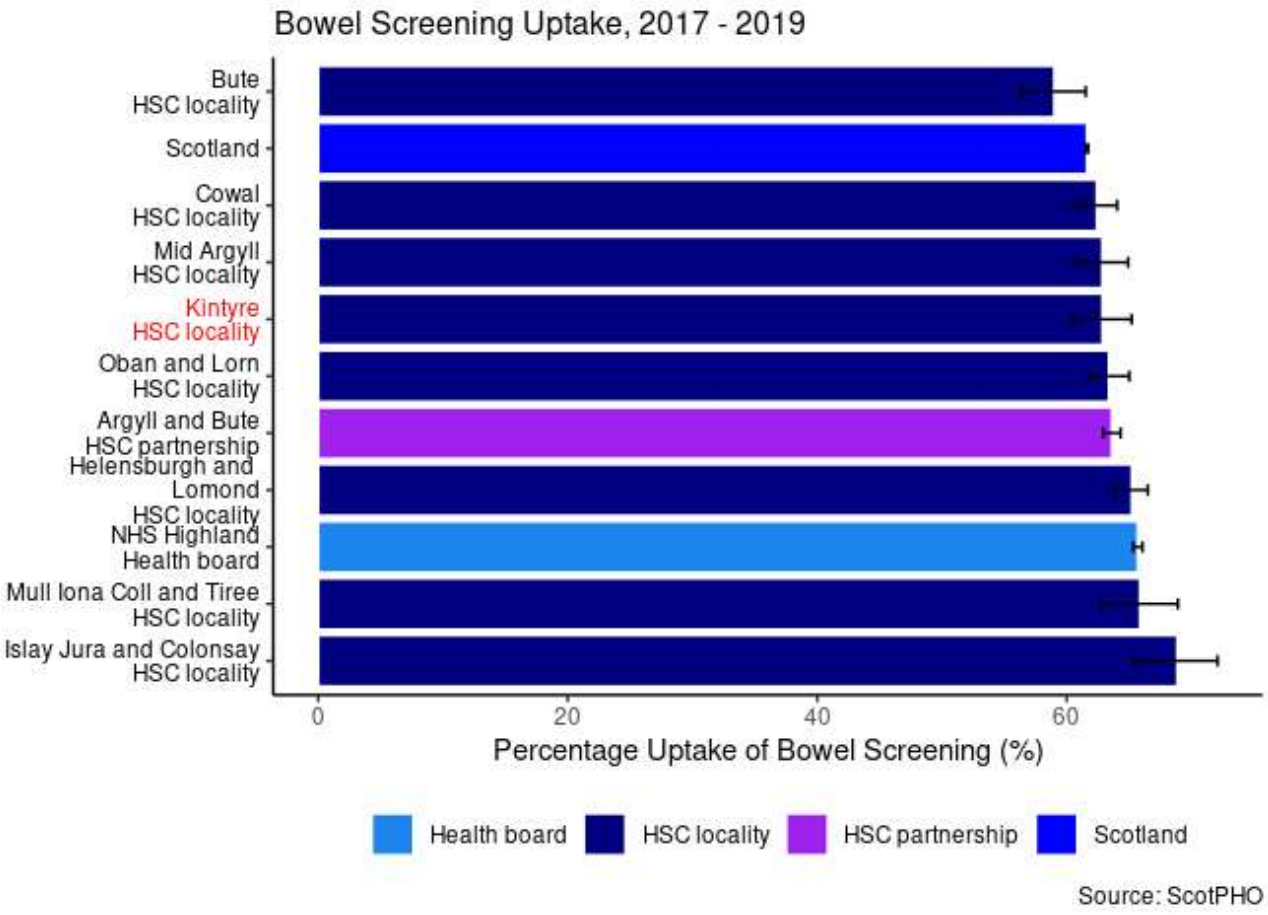
A trend of the percentage uptake of bowel screening among the eligible population is shown below for Kintyre locality compared with Scotland, Argyll and Bute HSCP and NHS Highland. Data is suppressed into 3 year aggregates. The 2017 - 2019 uptake rate for Kintyre is **63%**.

Figure 23: Trend of Bowel Screening Uptake for eligible men and women, by geographical area.



Compared with Scotland, Kintyre locality has a higher percentage uptake of bowel cancer screening for the period 2017 - 2019.

Figure 24: Comparison of Bowel Screening Uptake for 2017 - 2019.



Hospital and Community Care

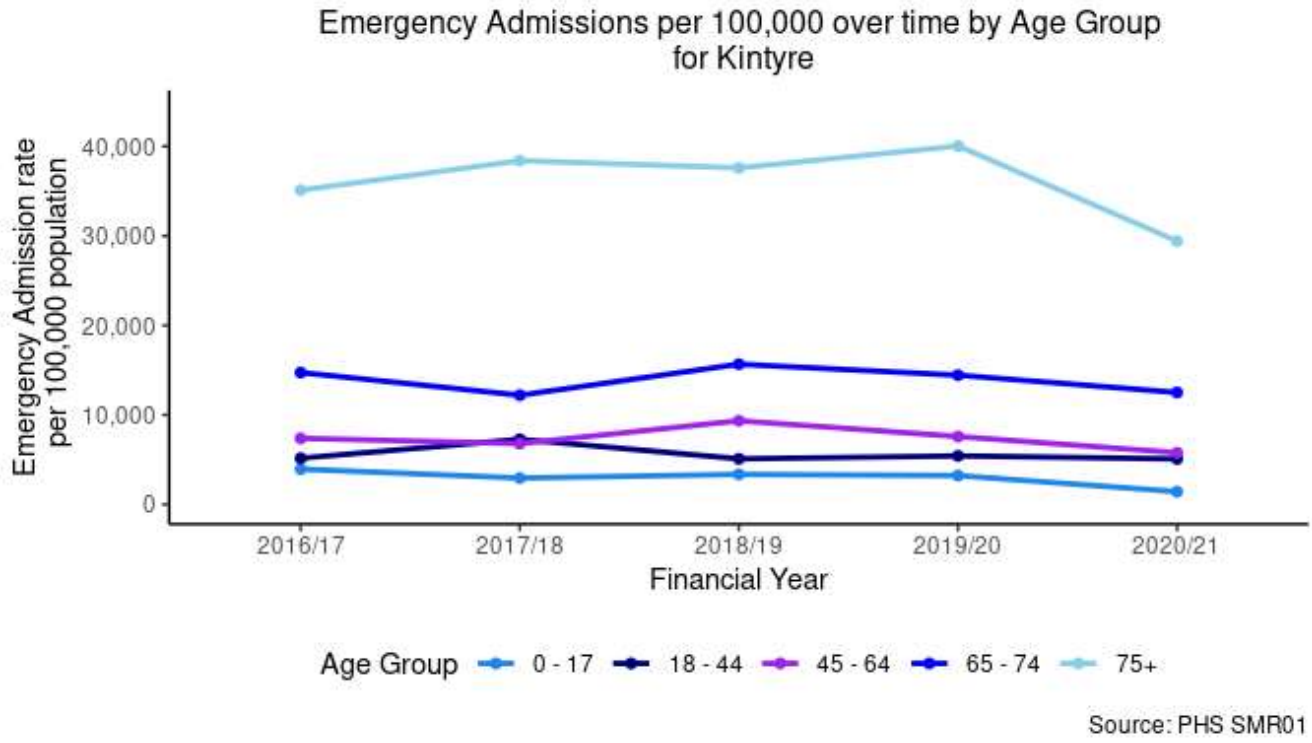
This section includes acute hospital data, delayed discharge bed days and A&E attendances. Please note that for 2020 onwards, hospital activity would have been severely affected by the COVID-19 pandemic. Information on how this has had a wider impact is provided in Footnote 6 at the end of the document.

For the most recent time periods available, Kintyre had:

- **8,990** emergency hospital admissions per 100,000 population.
- **72,081** unscheduled acute specialty bed days per 100,000 population.
- **2,237** A&E attendances per 100,000 population.
- **6,632** delayed discharge bed days per 100,000 population.
- **651** emergency hospital admissions from falls per 100,000 population.
- **103** emergency readmissions (28 day) per 1,000 discharges.
- **976** potentially preventable hospital admissions per 100,000 population.
- People on average spent **90%** of their last 6 months of life in a community setting.

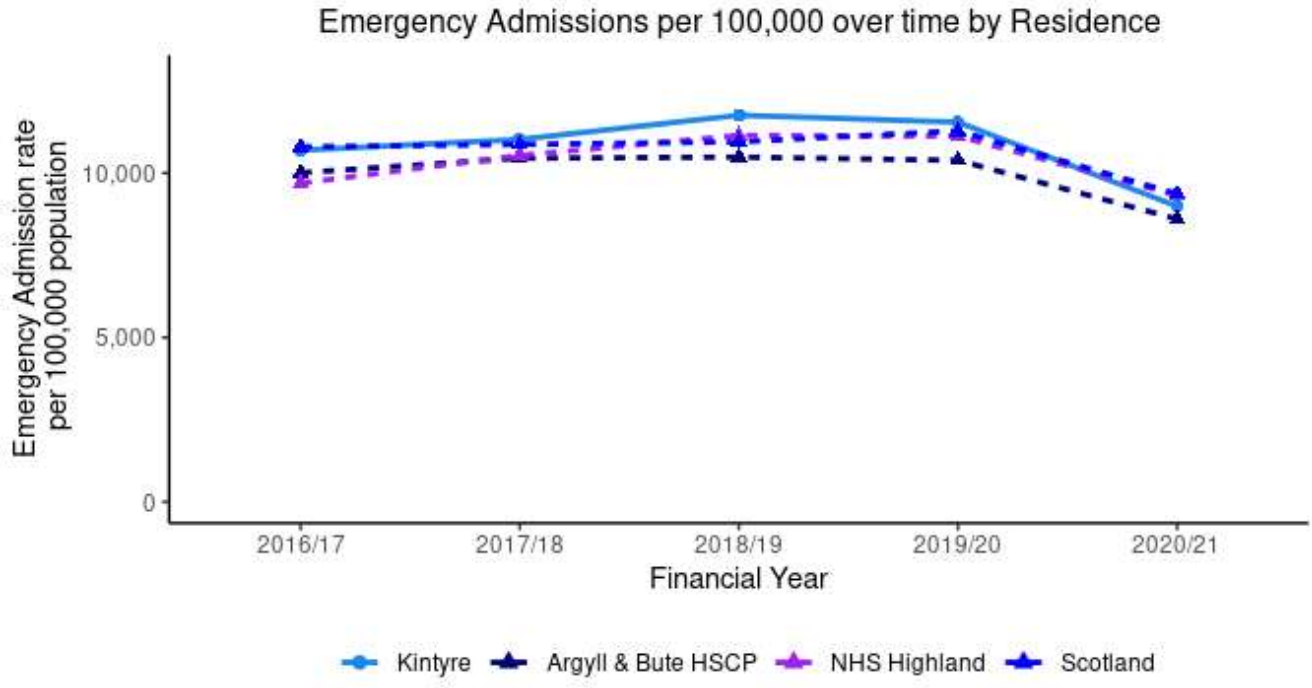
Emergency Admissions

Figure 25: Emergency admissions by age group



Source: PHS SMR01

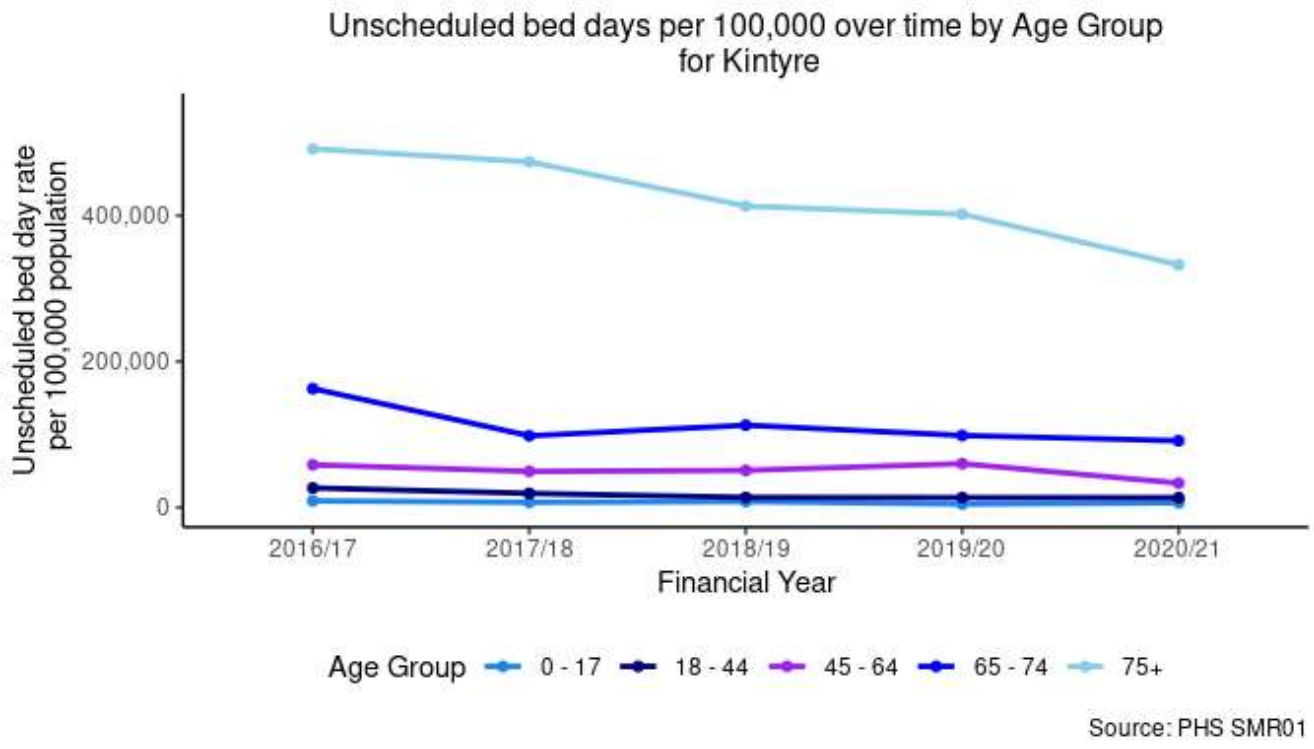
Figure 26: Emergency admissions by geographical area



Source: PHS SMR01

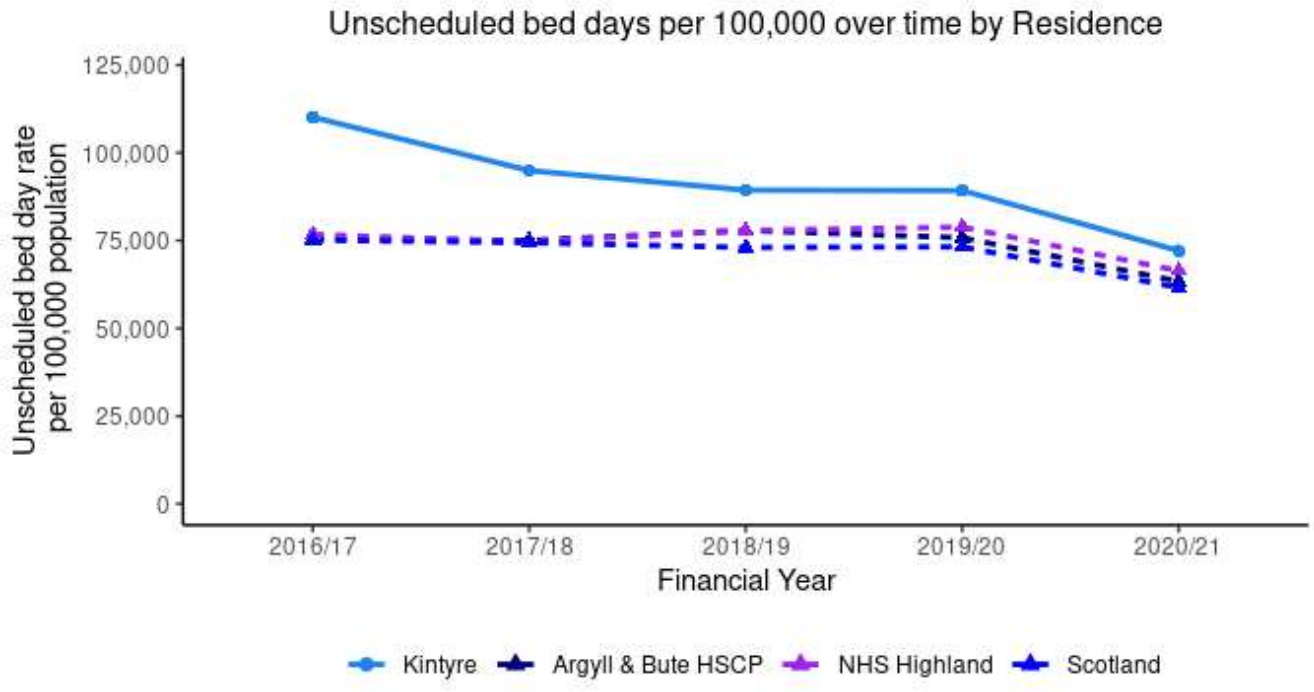
Unscheduled Acute Bed Days

Figure 27: Unscheduled bed days by age group



Source: PHS SMR01

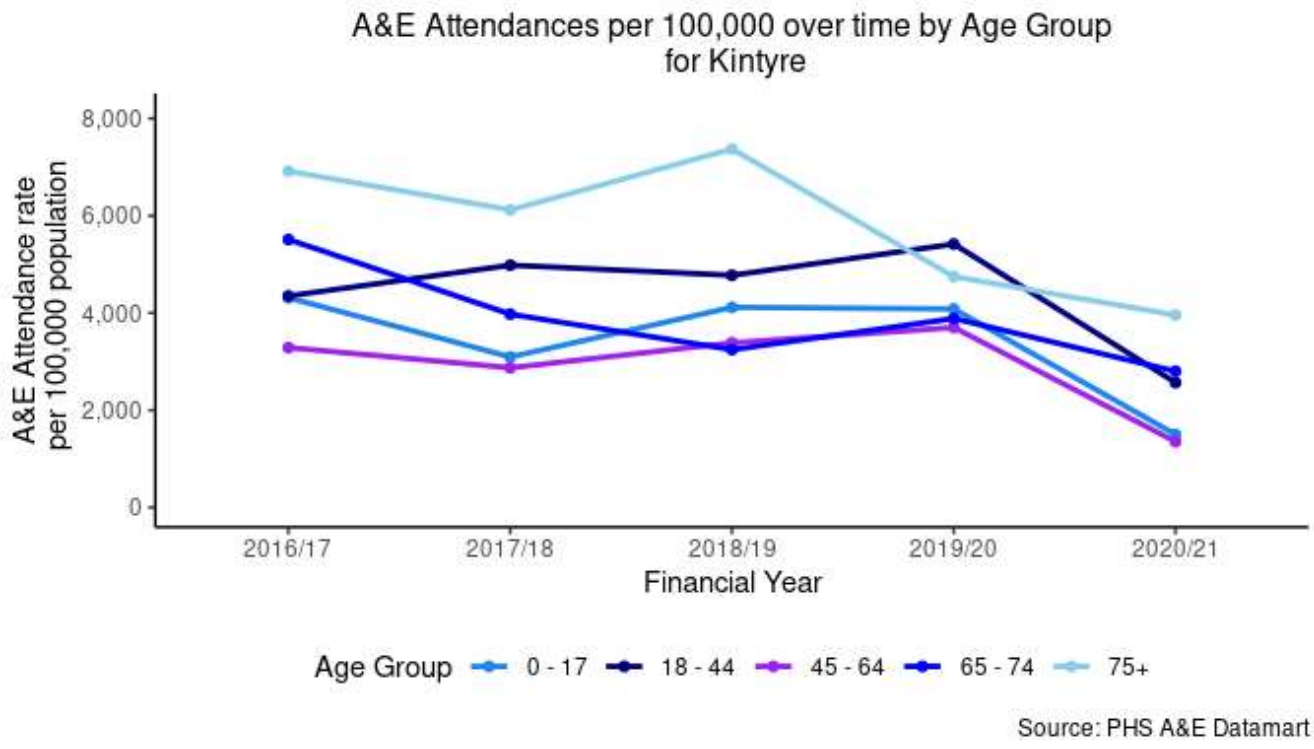
Figure 28: Unscheduled bed days by geographical area



Source: PHS SMR01

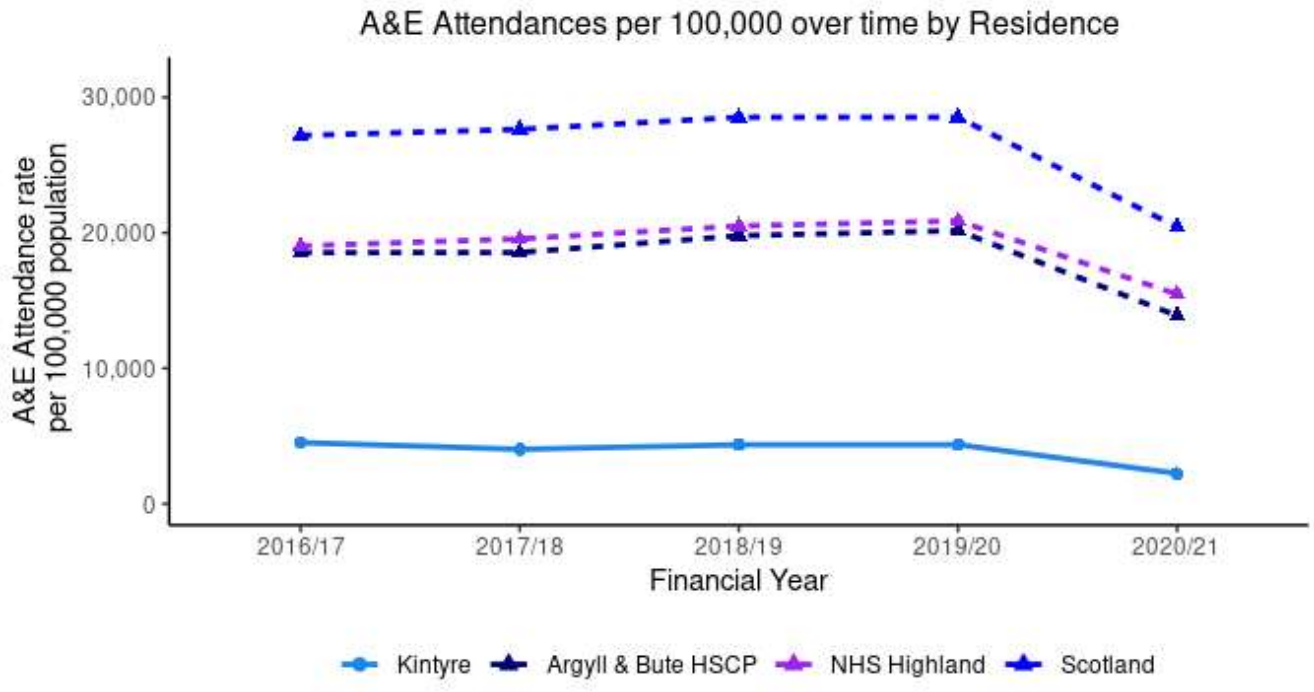
A&E Attendances

Figure 29: A&E attendances by age group



Source: PHS A&E Datamart

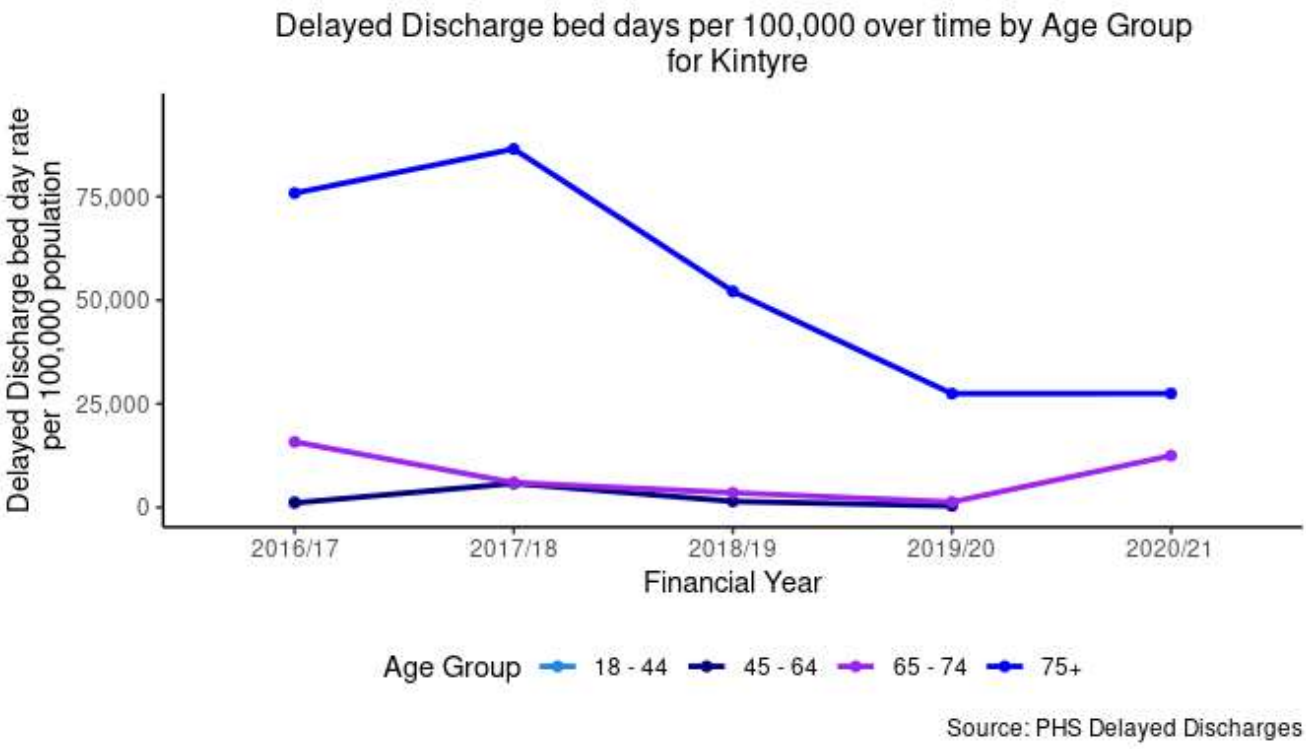
Figure 30: A&E attendances by geographical area



Source: PHS A&E Datamart

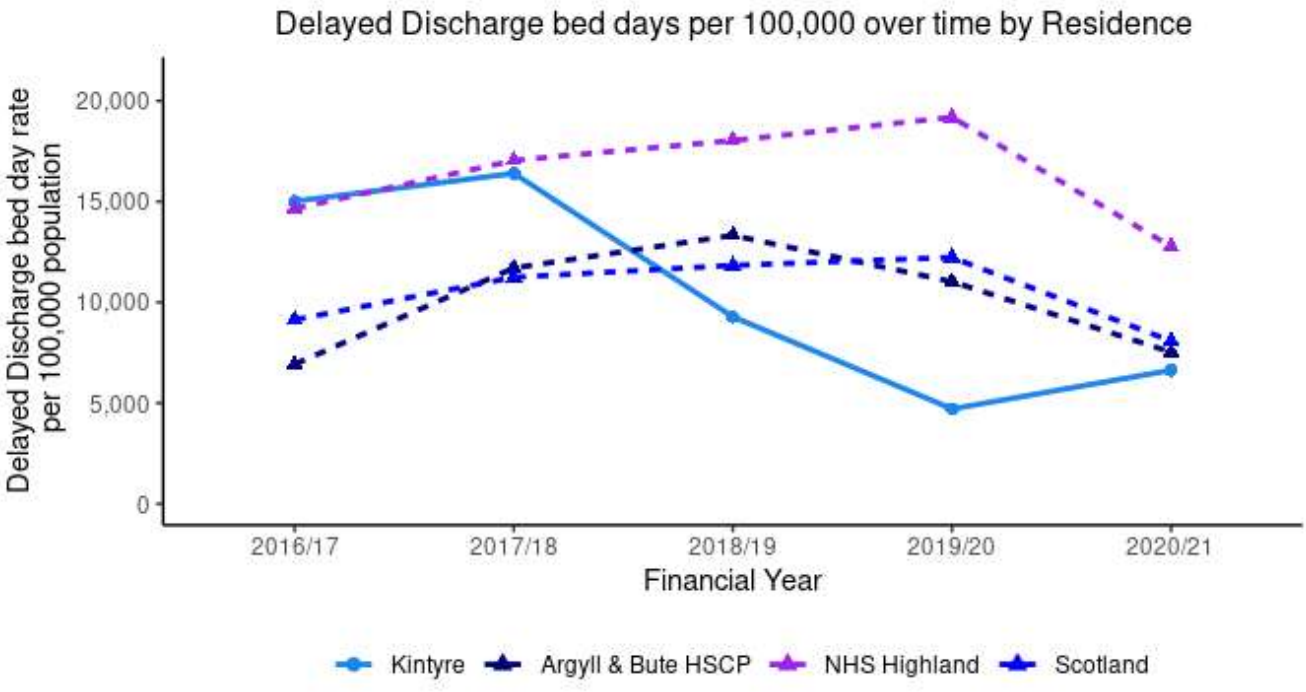
Delayed Discharge Bed Days

Figure 31: Delayed discharge bed days by age group



Source: PHS Delayed Discharges

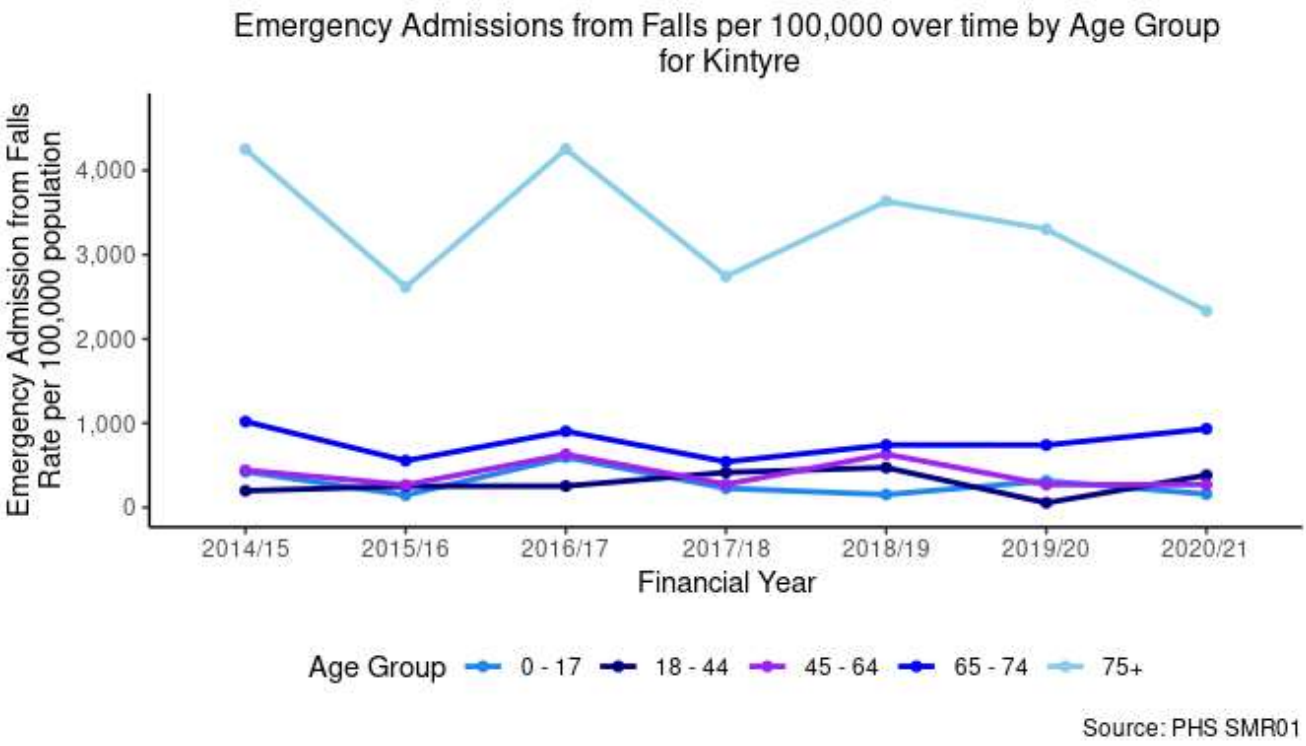
Figure 32: Delayed discharge bed days by geographical area



Source: PHS Delayed Discharges

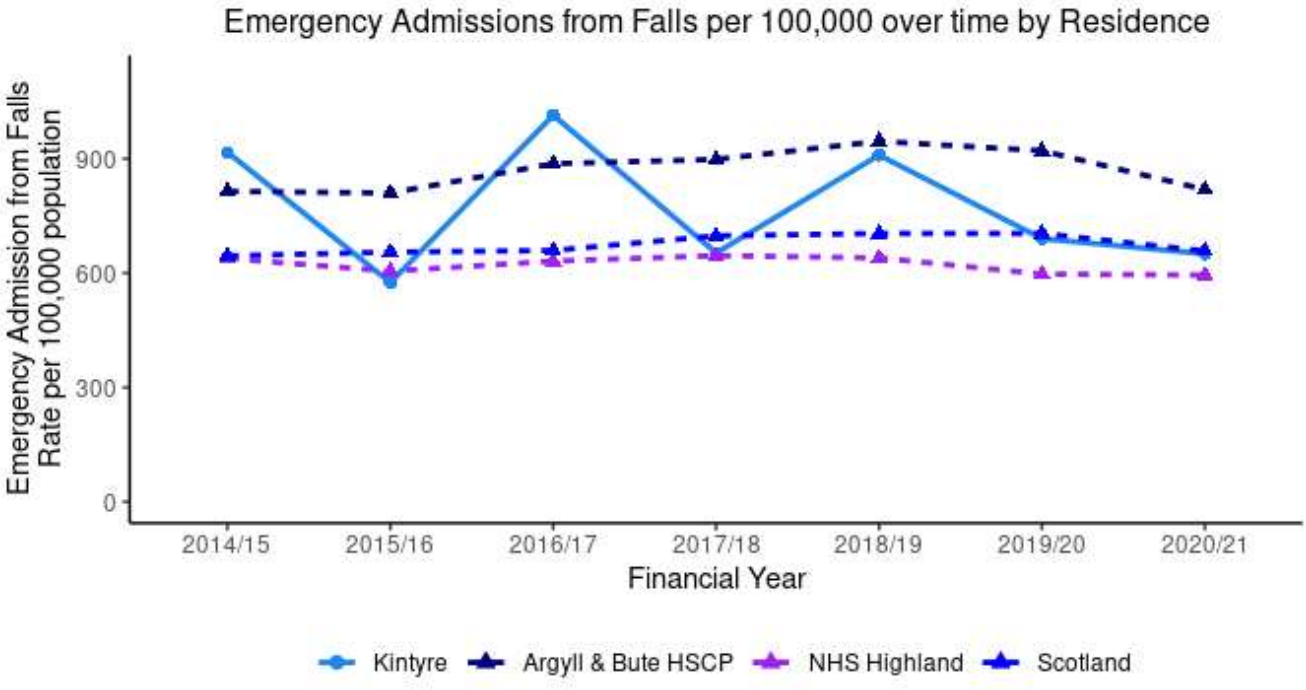
Emergency Admissions from a Fall

Figure 33: Falls by age group



Source: PHS SMR01

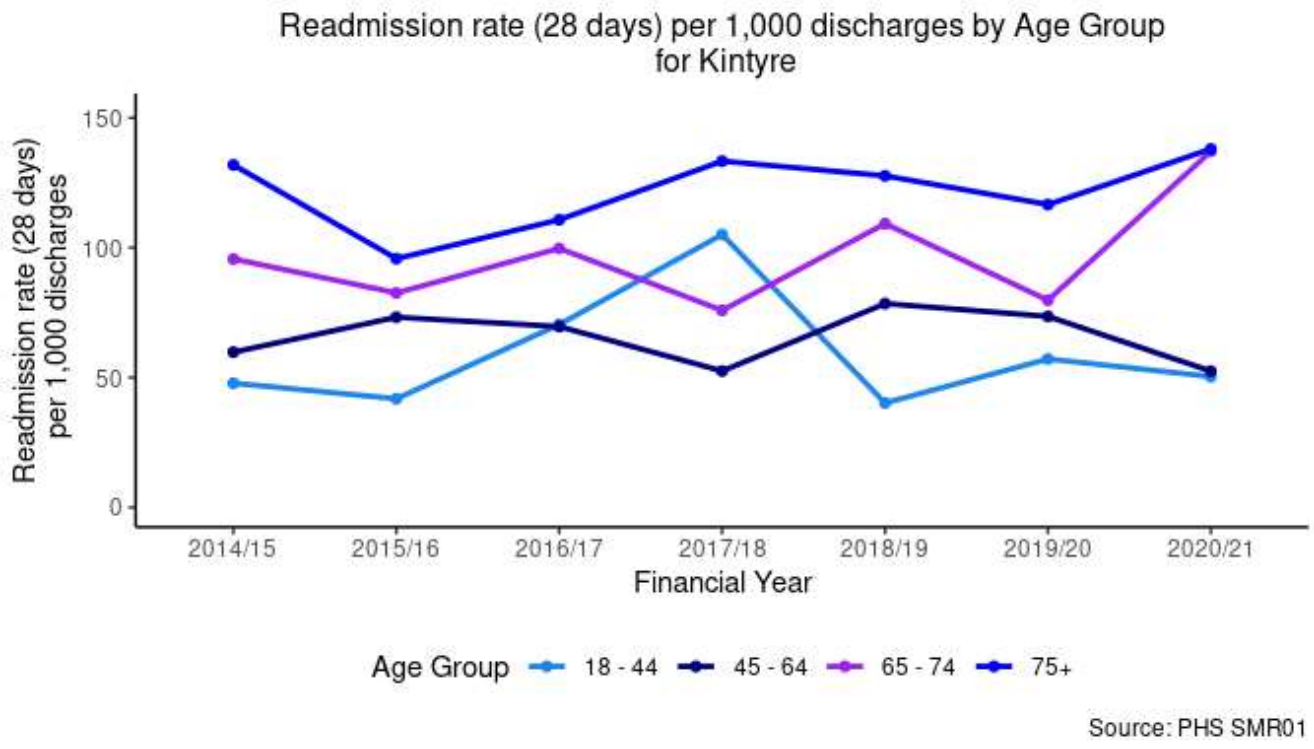
Figure 34: Falls by geographical area



Source: PHS SMR01

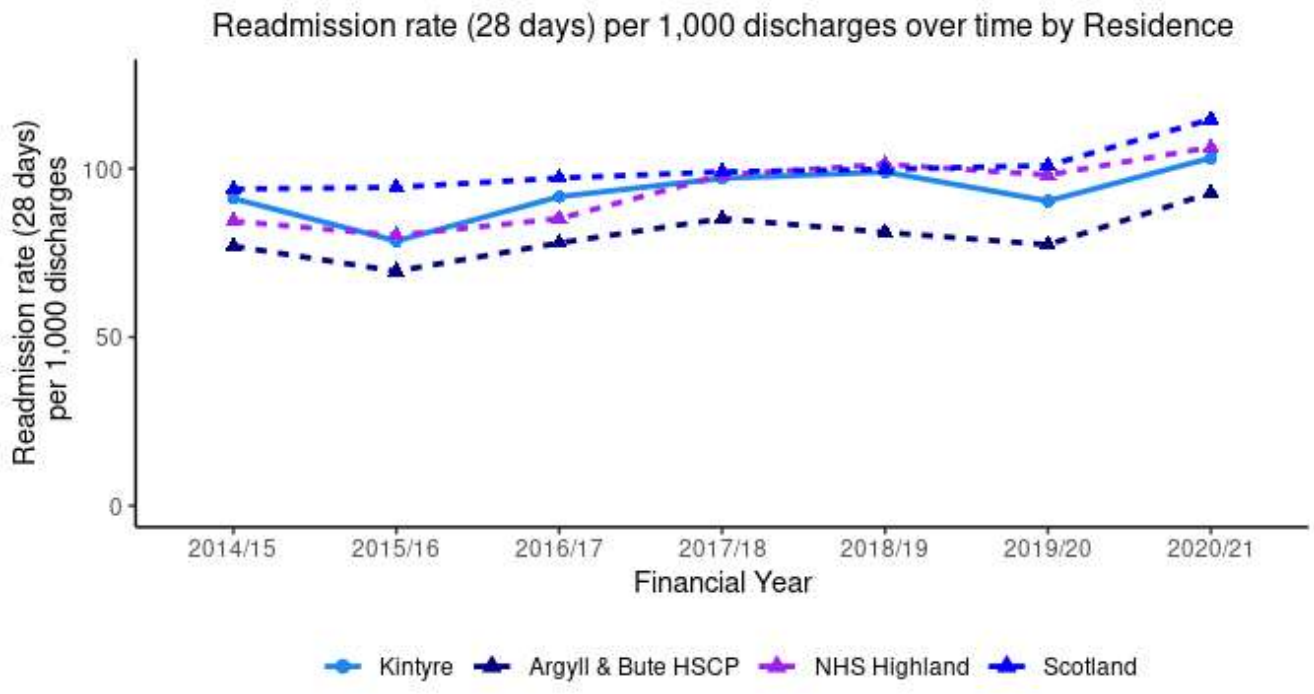
Emergency Readmissions (28 days)

Figure 35: Emergency readmissions by age group



Source: PHS SMR01

Figure 36: Emergency readmissions by geographical area

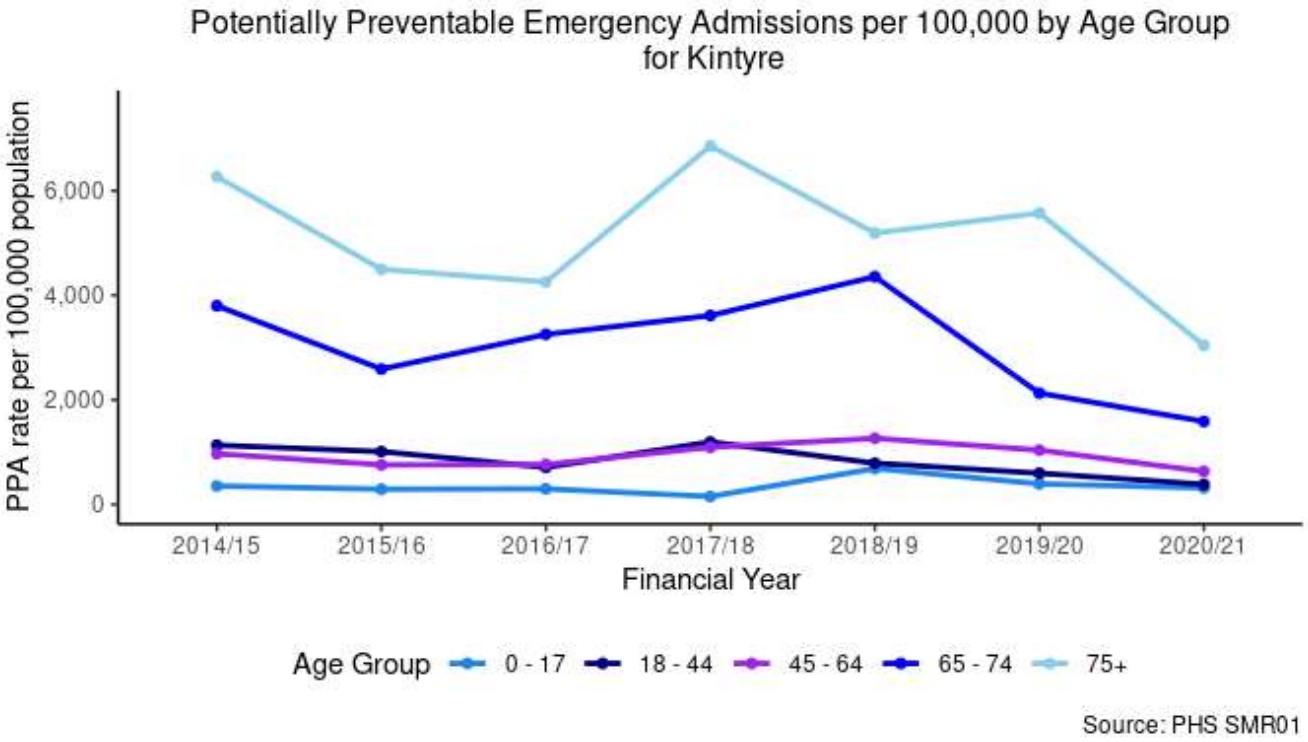


Source: PHS SMR01

Potentially Preventable Admissions (PPAs)

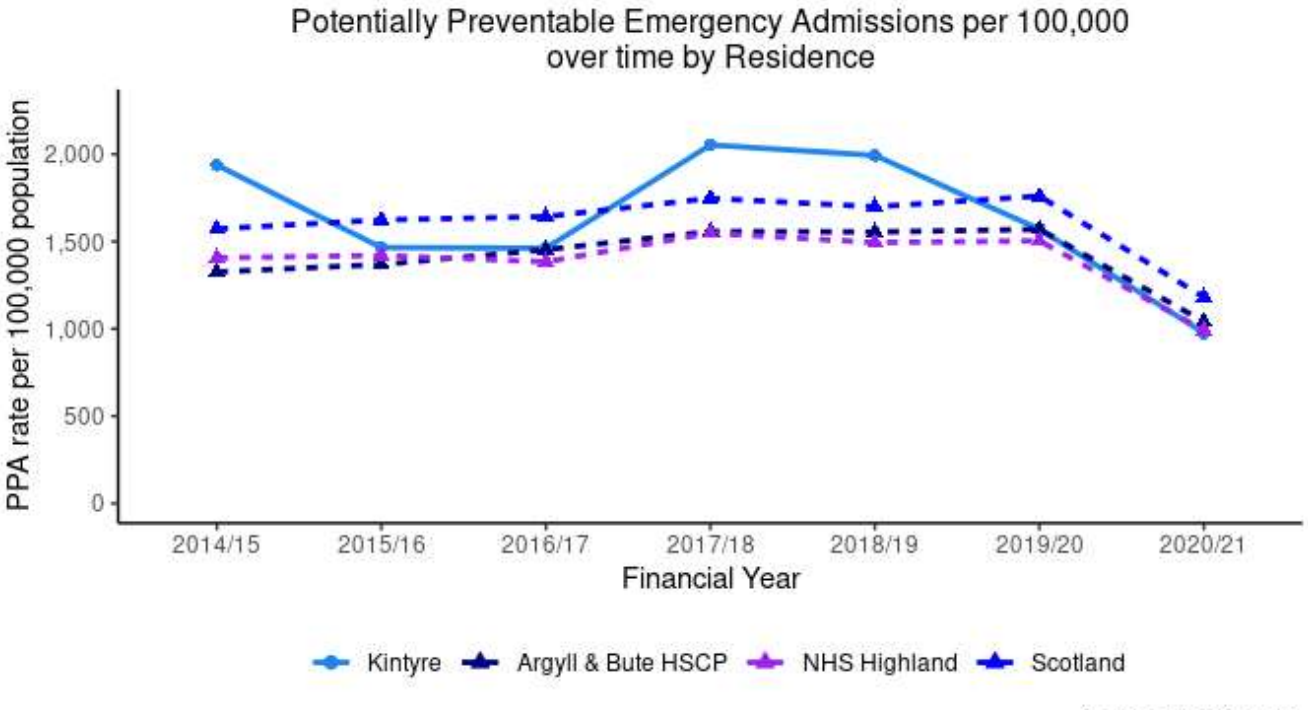
Information on which conditions are counted as PPAs is available in Appendix 3 in the accompanying summary document.

Figure 37: PPAs by age group



Source: PHS SMR01

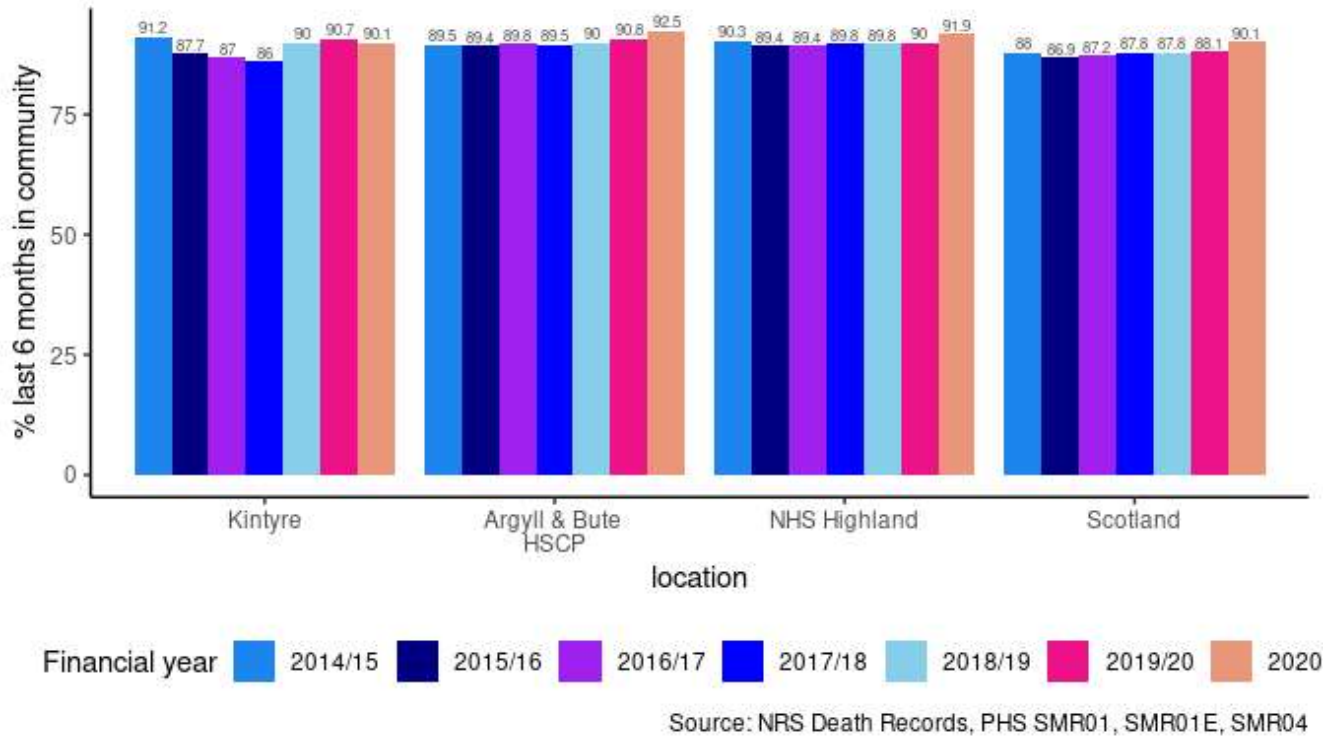
Figure 38: PPAs by geographical area



Source: PHS SMR01

% Last 6 months in a Community Setting

Figure 39: Last 6 months in a community setting by geographical area



Footnotes

1. Population projections are not currently provided by NRS at the locality level. To explore how the population in Kintyre is expected to change in the future, the percent changes in population projection to 2025 for Argyll and Bute by age group and gender were calculated from the NRS Local Authority Population Projections. These percent changes were then applied to the Kintyre 2018 mid-year population estimates (also split by age group and gender) to obtain population projection estimates for Kintyre, based on the projections for the HSCP and the current population structure of the locality.
2. Care Home Data included in the Services Map and Table was sourced from the Care Inspectorate. GP Practice data from October 2021, and Hospital and A&E data was sourced from Public Health Scotland Open Data. Only services that are within the physical boundary of the HSCP or Locality are included in the map and table, so there may be services outside Argyll and Bute which people may use but are not shown.
3. The data used in General Health and Behavioural Factors sections (except for long-term conditions) of this locality profile are taken from ScotPHO. There may be more recent data available for the indicators elsewhere.
4. Data taken from ScotPHO is often reported using the European Age-Sex Standardised Rate per 100,000. This allows for comparisons across different areas to be made. For more information on how these rates are calculated, please refer to www.isdscotland.org/Products-and-Services/GPD-Support/Population/Standard-Populations/
5. Physical long-term conditions data comes from the Source Linkage Files, and the conditions are identified using ICD-9 and ICD-10 codes in the diagnosis fields. Please note that the Source Linkage Files data only contains information on people who have had contact with the NHS through either inpatient admissions, outpatient attendances, daycase attendances, A&E attendances or through prescribed items, the data does not show all service users in Scotland who have been diagnosed with an LTC as not all of these individuals will have used these services. Also note that LTC rates are based on an adjusted population indicator in the Source Linkage Files so that population sizes are closer to the official estimates.
6. The 2020 COVID-19 pandemic will have had an effect on the most recent data available. A dashboard has been created by PHS which show the wider impacts of COVID-19 over many areas. You can access this here: https://scotland.shinyapps.io/phs-covid-wider-impact/

Locality Profile

Islay Jura and Colonsay Locality

October 2021

Table of Contents

Notes for this profile:

- The island of Colonsay is located in the HSCP locality of ‘Oban, Lorn and the Isles’ (OLI) and within the local area of ‘Mull, Iona, Coll, Tiree and Colonsay’. This reflects the organisation and delivery of HSCP services to Colonsay from OLI. However, to compile these profiles, data are aggregated from small geographical areas called datazones, for which different data are made available across Scotland. Colonsay is included within a datazone with Jura. This reflects the political multi-councillor ward in which Colonsay is placed with Islay, Jura and Kintyre (and falls within the Argyll and Bute Council Administrative Area of ‘Mid-Argyll, Kintyre and Islay’). Colonsay is therefore included with Islay and Jura in the profile area of ‘Islay, Jura and Colonsay’.
- All years shown are calendar years unless otherwise specified.
- Upper and lower 95% confidence intervals are shown throughout this document where available. In charts, these are displayed as shaded areas either side of trend lines, or as black error bars in bar charts. Confidence intervals show the range of possible values and a certainty that the true value falls within them.
- Definitions for the indicators shown are available in Appendix 1 in the accompanying summary document.
- Any zero figures for some indicators will indicate either suppression of small data or a complete lack of data available for this locality
- Data should be interpreted with caution, particularly for areas with relatively small population sizes where indicator data is expected, by chance alone, to have higher variation than in areas of larger population size. Note that differences between areas can relate to multiple factors including, for example, underlying rates of illness, rates of diagnosis and local differences in practice e.g. in data recording.

Demographics

Summary:

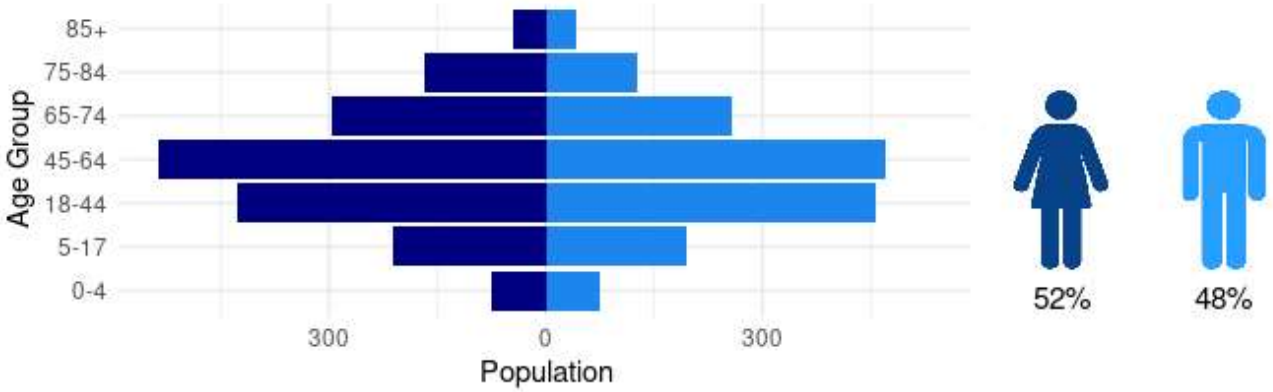
For the most recent time periods available, Islay Jura and Colonsay Locality had:

- A total population of **3,380** people, where **48%** were male, and **28%** were aged over 65.
- **0%** of people lived in the least deprived SIMD quintile, and **0%** lived in the most deprived quintile.

Population

In 2020, the total population of Islay Jura and Colonsay locality was 3,380. The graph below shows the population distribution of the locality.

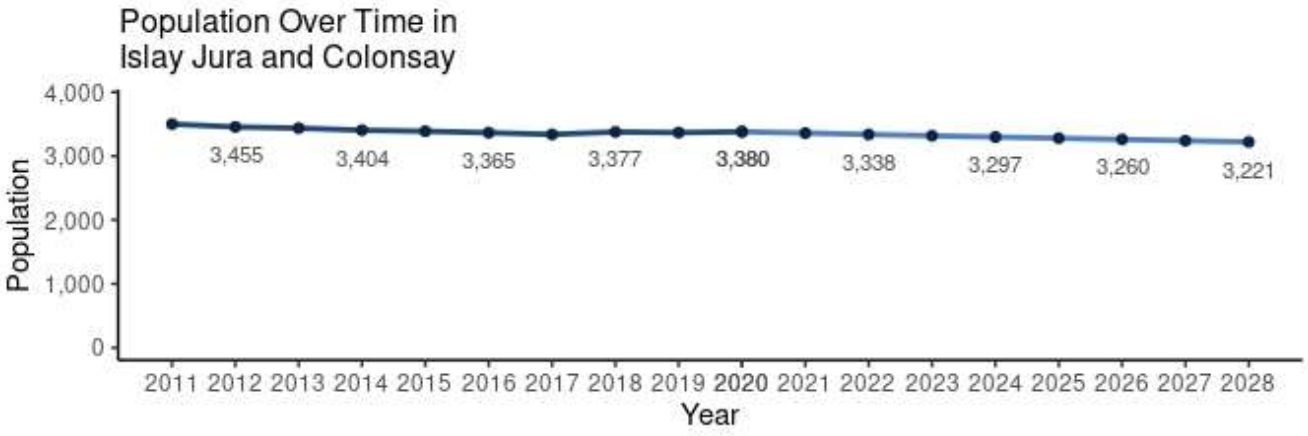
Figure 1: Population breakdown in Islay Jura and Colonsay.



Source: National Records Scotland

Figure 2 shows the historical population of Islay Jura and Colonsay, along with the NRS population projections. The population has been falling in general, however it has risen since last year. The population in Islay Jura and Colonsay is estimated to decrease by 3% from 2020 to 2025 *Please see the footnotes for more information on how the population projections were calculated*[1].

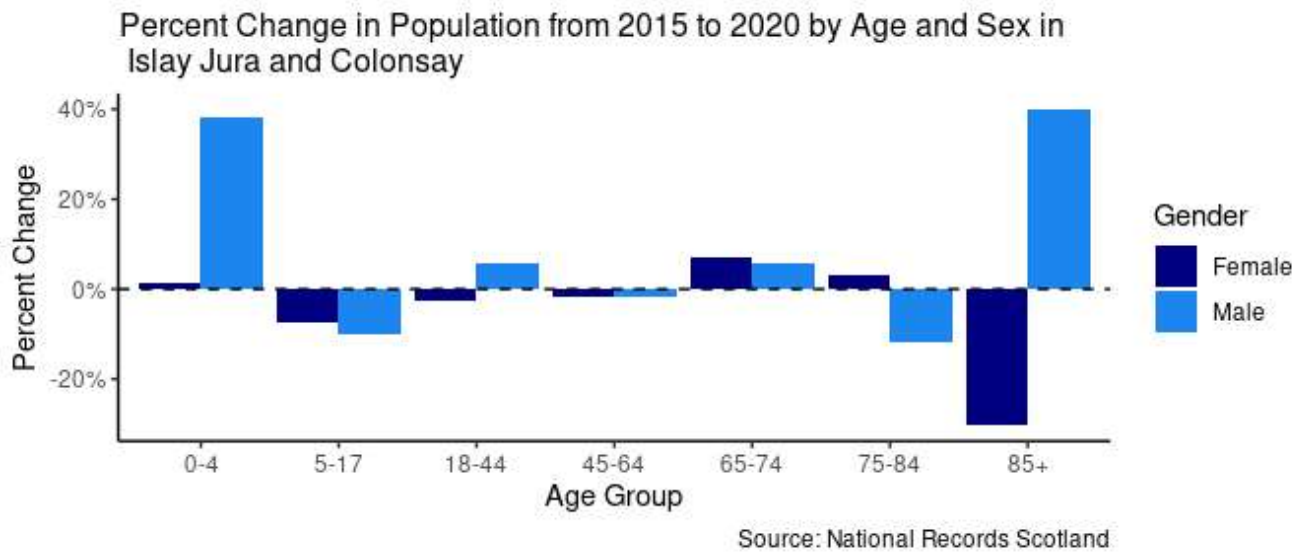
Figure 2: Population time trend and projection.



Source: National Records Scotland

Figure 3 shows how population structure has changed between 2015 and 2020.

Figure 3: Change in population structure over the last five years.



Deprivation

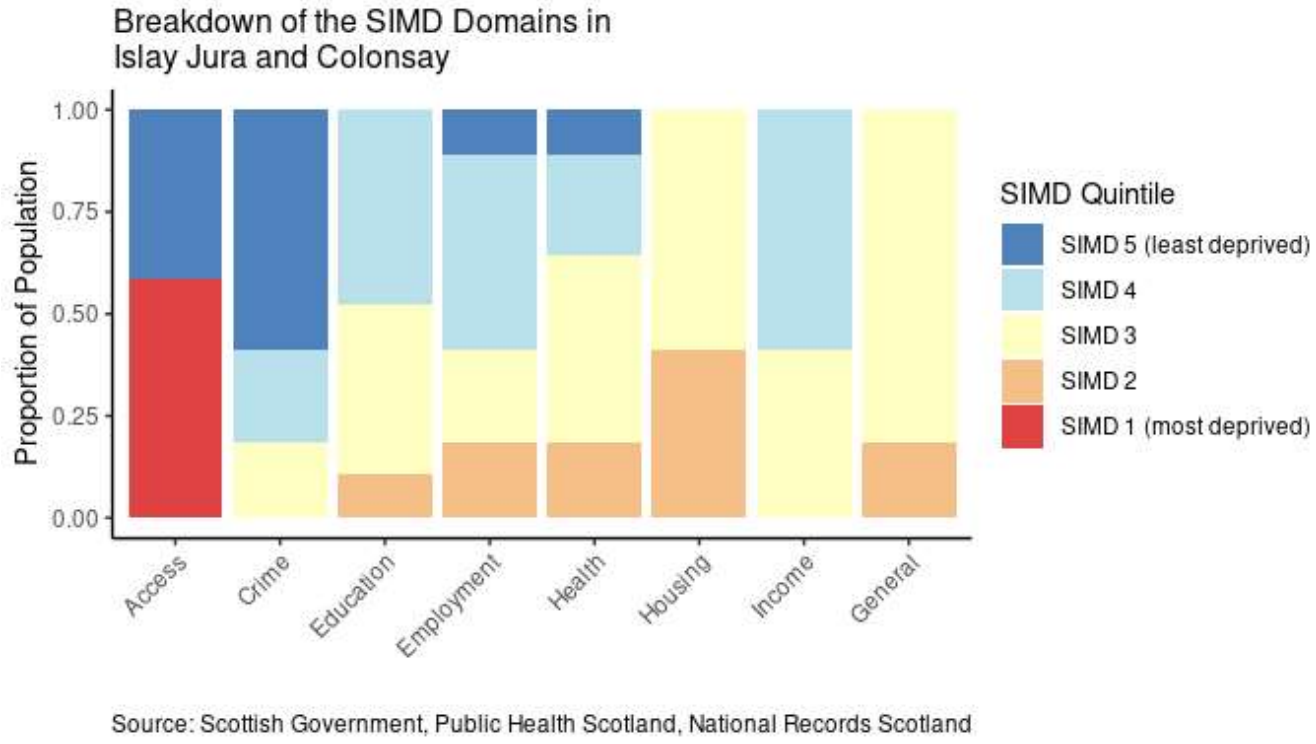
The following section explores the deprivation structure of Islay Jura and Colonsay through the Scottish Index of Multiple Deprivation (SIMD). The SIMD ranks all datazones in Scotland by a number of factors; Access, Crime, Education, Employment, Health, Housing and Income. Based on these ranks, each datazone is then given an overall deprivation rank, which is used to split datazones into Deprivation Quintiles (Quintile 1 being the most deprived, and Quintile 5 the least). The most recent SIMD ranking was carried out in 2020. This section mainly focuses on the SIMD 2020 classifications, however the 2016 classifications are used to assess how deprivation has changed in Islay Jura and Colonsay when compared to the rest of Scotland.

Of the 2020 population in Islay Jura and Colonsay, **0%** live in the most deprived SIMD Quintile, and **0%** live in the least deprived SIMD Quintile. The following table details the percent of the population living in the 2016 SIMD Quintiles, the percent living in the 2020 SIMD Quintiles, and their difference for comparison.

Table 1: Percentage population living in the 2016 and 2020 SIMD Datazone Quintiles

Quintile	Percent of Pop (2016)	Percent of Pop (2020)	Difference
SIMD 1	0.0%	0.0%	0.0%
SIMD 2	20.3%	18.5%	-1.8%
SIMD 3	79.7%	81.5%	1.8%
SIMD 4	0.0%	0.0%	0.0%
SIMD 5	0.0%	0.0%	0.0%

Figure 4: Proportion of the population that reside in each 2020 SIMD quintile by domain.



Source: Scottish Government, Public Health Scotland, National Records Scotland

Households

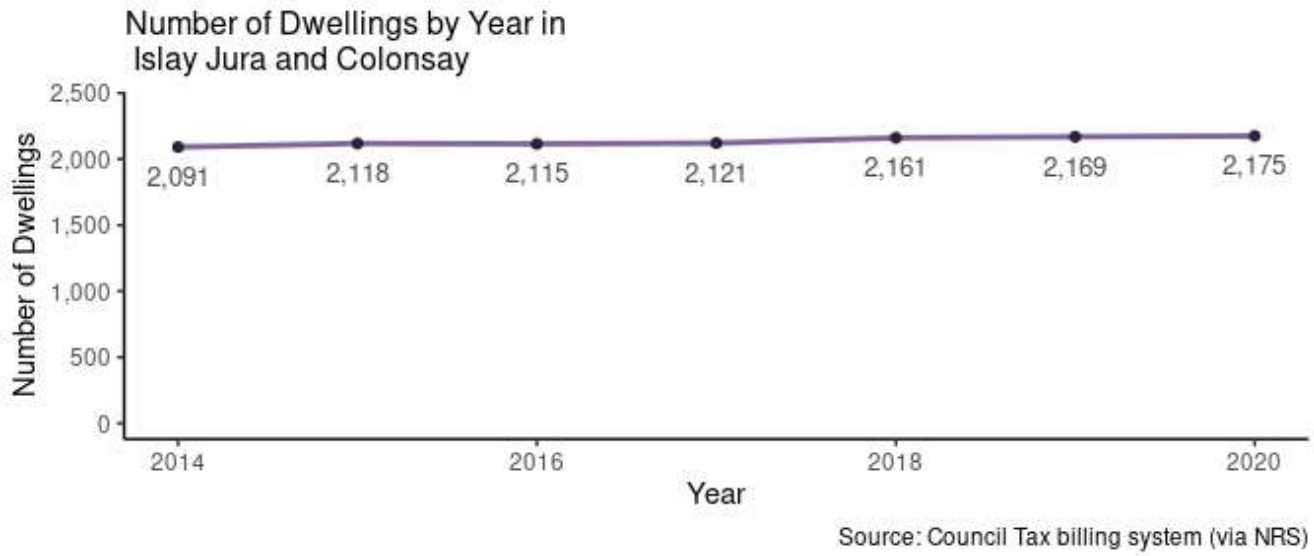
Summary:

For the most recent time periods available, Islay Jura and Colonsay Locality had:

- **2,175** dwellings, of which: **83%** were occupied and **12%** were second homes.
- **29%** of dwellers received a single occupant council tax discount, and **0.78%** were exempt from council tax entirely.
- **68%** of houses were within council tax bands A to C, and **6.4%** were in bands F to H.

The graph below shows the number of dwellings in Islay Jura and Colonsay from 2014 to 2020.

Figure 5: Number of dwellings time trend.



Of the total number of dwellings in 2020, 29% (638 households) were occupied by an individual receiving a single occupant council tax discount. Furthermore, 0.78% (17 households) were occupied and exempt from council tax.

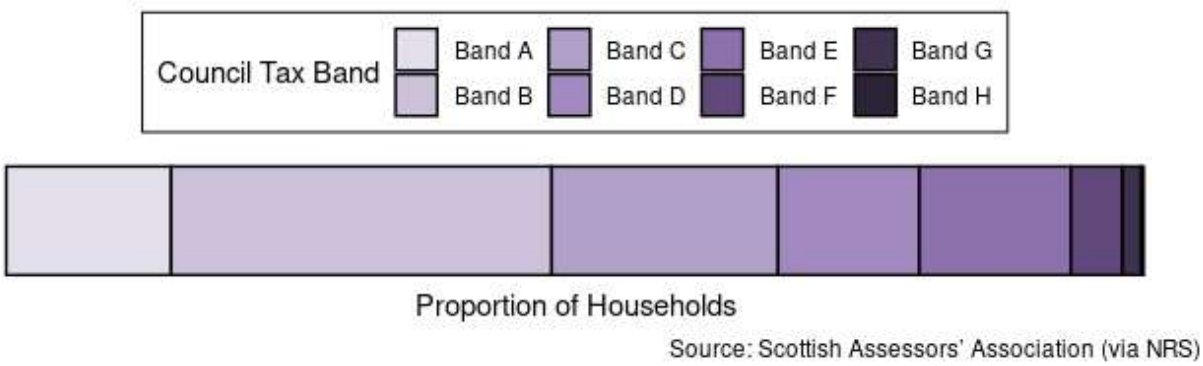
There were 261 dwellings classed as a second home in 2020, these dwellings made up 12% of the households in Islay Jura and Colonsay.

Table 2: Breakdown of dwelling types by year for Islay Jura and Colonsay locality.

Year	Total Dwellings	Occupied Dwellings	Vacant Dwellings	Single Occupant Tax Discount	Council Tax Exempt Dwellings	Second Homes
2014	2,091	1,713	122	643	11	256
2015	2,118	1,737	115	636	11	266
2016	2,115	1,738	110	637	10	267
2017	2,121	1,723	130	599	8	268
2018	2,161	1,777	119	629	15	265
2019	2,169	1,800	106	636	16	263
2020	2,175	1,803	112	638	17	261

The proportion of households within each council tax band are displayed in the chart below, figures are shown in Table 3.

Figure 6: Breakdown of households by council tax band for Islay Jura and Colonsay in 2020.



Source: Scottish Assessors' Association (via NRS)

Table 3: Percentage of households by council tax band for Islay Jura and Colonsay in 2020.

Tax Band	A	B	C	D	E	F	G	H
Percent of households	15%	33%	20%	12%	13%	4.5%	1.6%	0.23%

General Health

Summary:

For the most recent time periods available[3], Islay Jura and Colonsay Locality had:

- **An average life expectancy of 77.4 years for males and 82.3 years for females.**
- **A death rate for ages 15 to 44 of 30 deaths per 100,000 age-sex standardised population[4]**
- **25%** of the locality's population with at least one long-term physical health condition.
- A cancer registration rate of **472** registrations per 100,000 age-sex standardised population[4]
- **23.85%** of the population being prescribed medication for anxiety, depression, or psychosis.

Life Expectancy

In the latest time period available from 2016-2020 (5 year aggregate), the average life expectancy in Islay Jura and Colonsay locality was 77.4 years old for men, and 82.3 years old for women. A time trend since 2013-2017 can be seen in figure 8.

Figure 8: Average life expectancy in men and women over time.

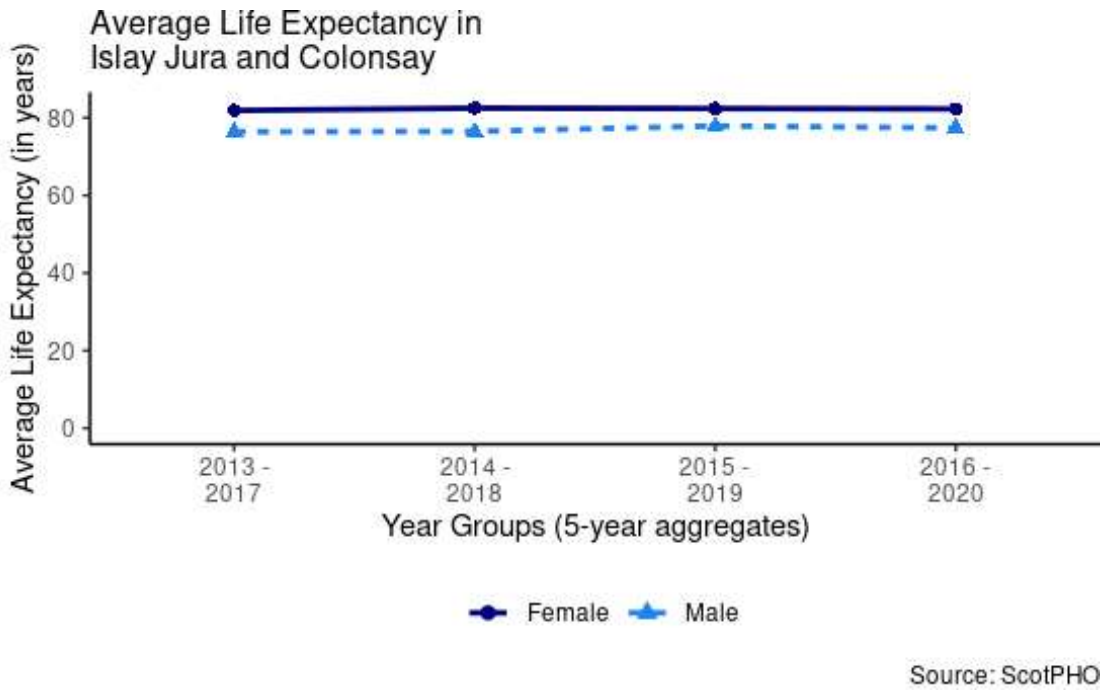


Table 5 provides the average life expectancy for men and women in different areas for the latest time period available. Please note that these are 5 year aggregates for the locality from 2016-2020, but 3 year aggregates from 2018-2020 at partnership, Health Board, and Scotland level.

Table 5: Average life expectancy in years for the latest time periods (2016-2020 aggregated years for the locality; 2018-2020 aggregated years for other areas).

	Locality	Partnership	Health Board	Scotland
	82.3	81.6	81.8	81
	77.4	78	77.6	76.8

Where Locality = Islay Jura and Colonsay, Partnership = Argyll and Bute HSCP, Health Board = NHS Highland.

Deaths, aged 15-44

The following chart shows a trend of death rates among 15-44 year olds per 100,000 age-sex standardised population[4] by area (i.e. Early mortality rate per 100,000). In the most recent aggregate time period available (from 2018-2020), the mortality rate in Islay Jura and Colonsay locality was **30** deaths per 100,000 population. Figure 10 then provides comparisons of deaths for all localities in Argyll and Bute HSCP, for the two latest time aggregates available.

Figure 9: Deaths aged 15-44 years by geographical area and over time.

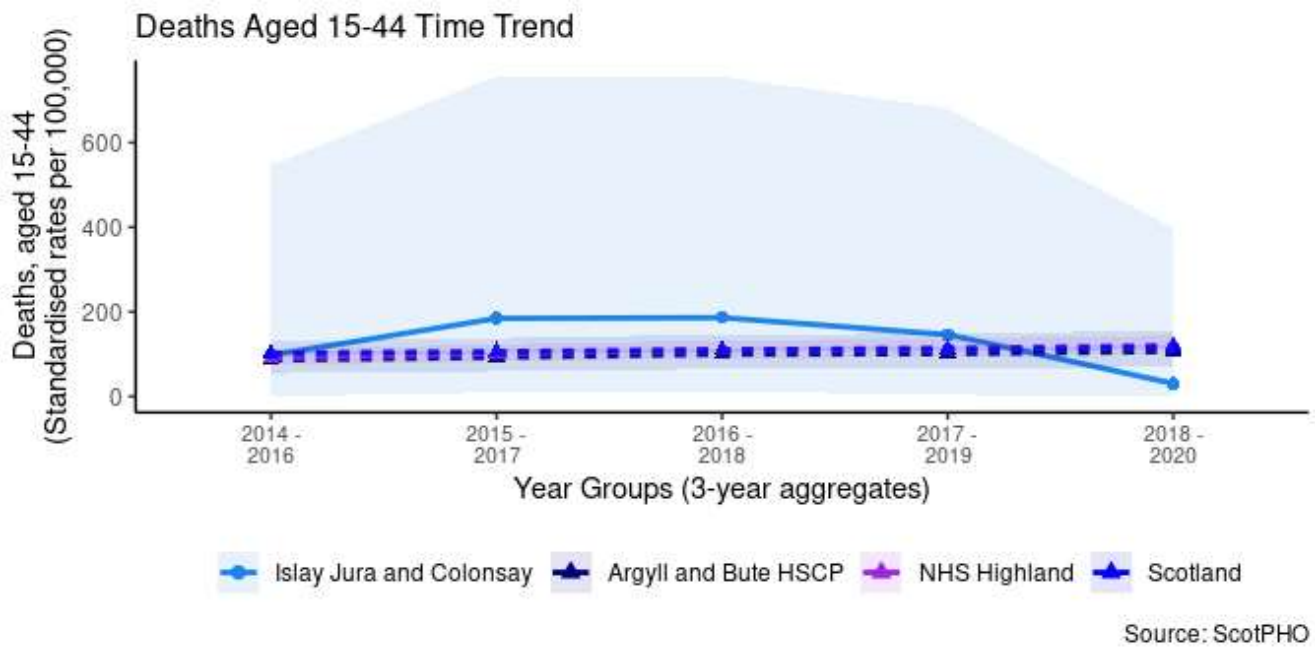
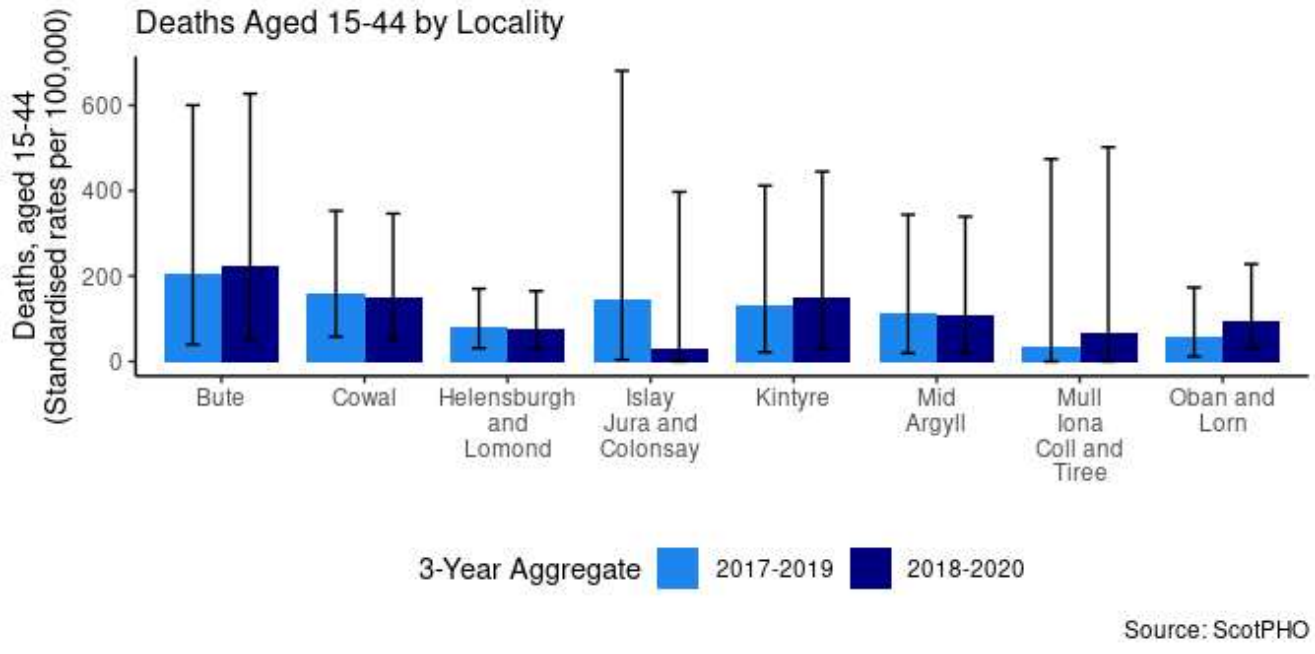
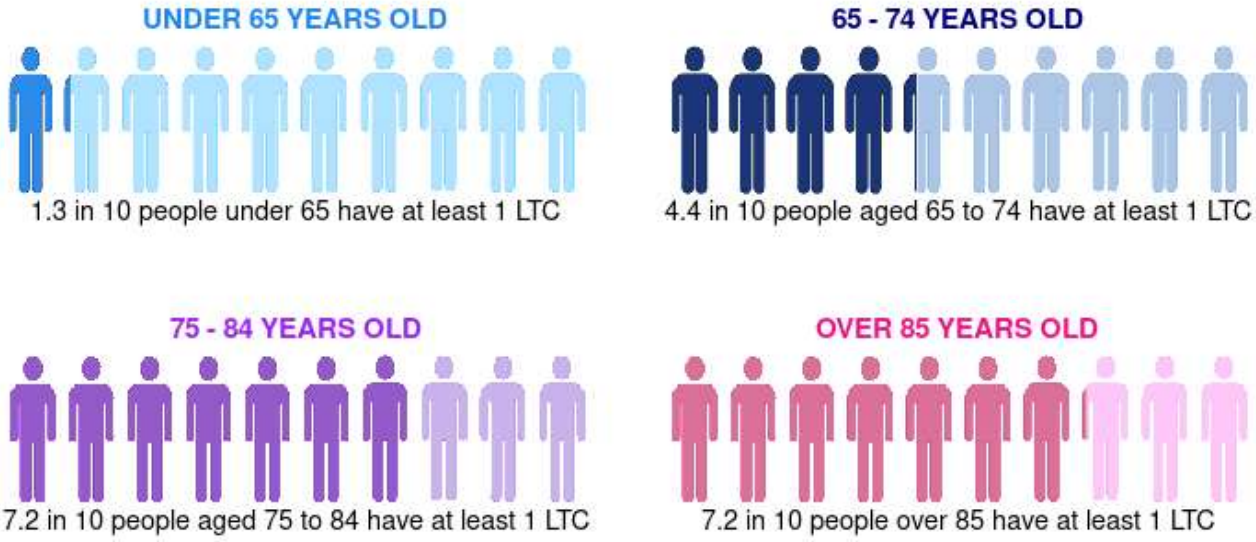


Figure 10: Deaths at ages 15-44 in Argyll and Bute HSCP localities.



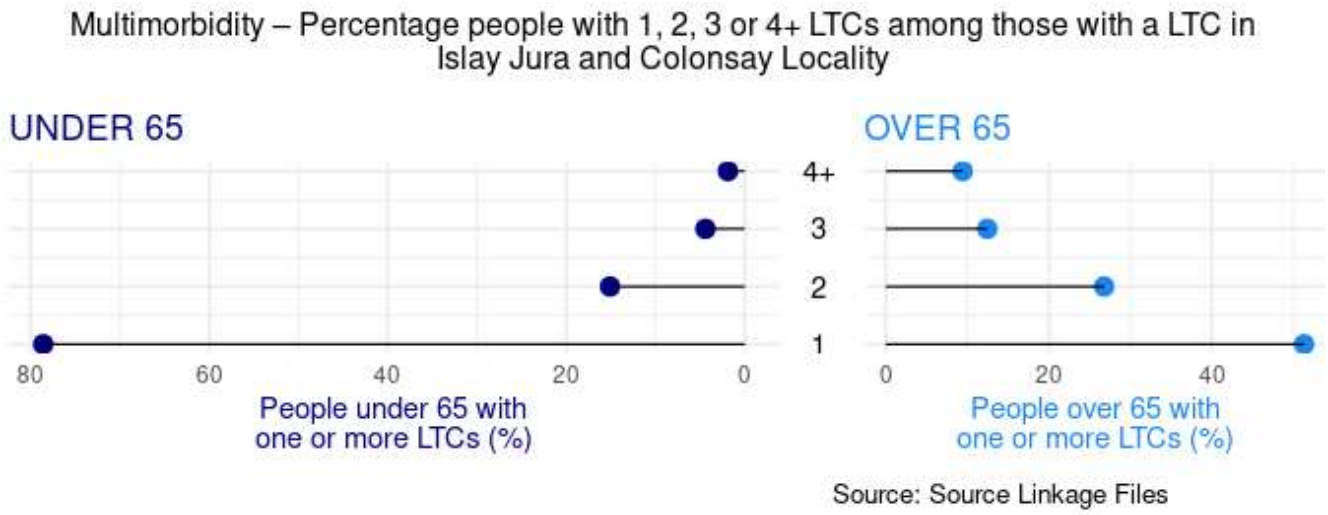
Long-Term Physical Health Conditions and Multimorbidity

In the financial year 2020/21, in Islay Jura and Colonsay Locality, **25%** of the total population had at least one physical long-term condition (LTC). These include: cardiovascular, neurodegenerative, and respiratory conditions, as well as other organ conditions (namely liver disease and renal failure), arthritis, cancer, diabetes, and epilepsy. *Please see footnotes for information and caveats on identifying LTCs.*[5]



The co-occurrence of two or more conditions, known as multimorbidity, is broken down in figure 11, distinguishing between age groups. Note that this chart *excludes* the population in the locality who do not have any physical long-term conditions. Figure 13 therefore shows that among the people who have a LTC, **21**% of those under the age of 65 have more than one, compared to **49**% of those aged over 65.

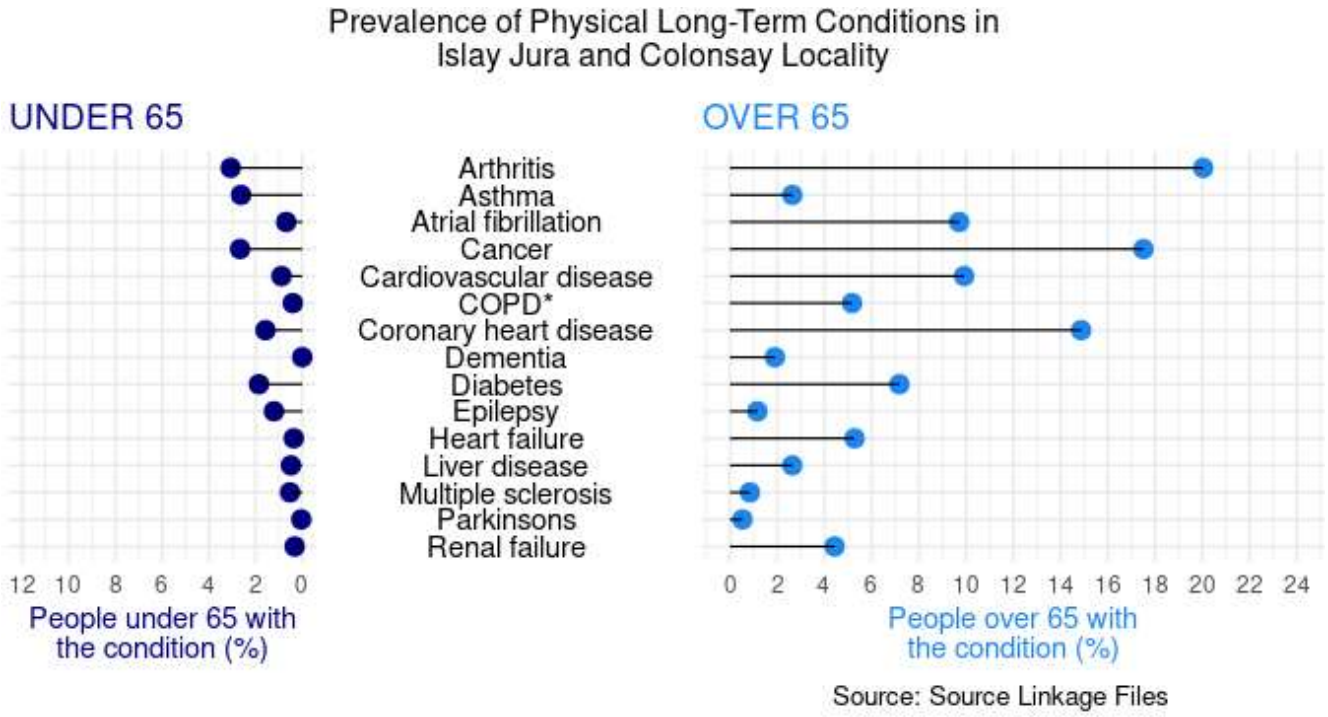
Figure 11: Multimorbidity of physical long-term conditions by age group in 2020/21.



Most common physical Long-Term Conditions (LTCs)

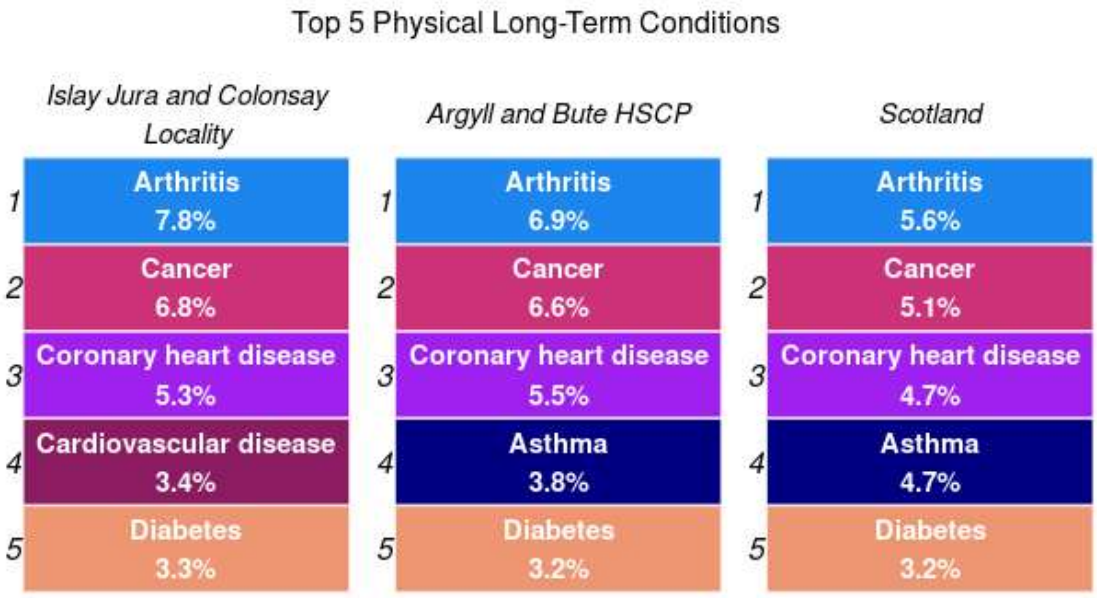
Below is a breakdown of the physical LTCs, for the financial year 2020/21. Figure 12 shows the prevalence of different LTCs in each age group in Islay Jura and Colonsay locality, and Table 6 illustrates the top 5 physical LTCs across all ages at locality, partnership, and Scotland level.

Figure 12: Percentage people with each physical LTC, split by age group.



**COPD: Chronic Obstructive Pulmonary Disease*

Table 6: Prevalence of the five most common physical LTCs as a percentage of the population across geographical areas (where 1 = most prevalent).



Cancer Registrations

For the period 2017-2019, there were 20 new cancer registrations per year on average (**472** registrations per 100,000 age-sex standardised population) in Islay Jura and Colonsay locality. This is a **1.8%** increase in cancer registrations rate from the previous aggregate period 2016-2018. Figure 13 shows changes over time since 2014-2016, and Figure 14 compares the rates of localities in Argyll and Bute HSCP for the two latest available time periods.

Figure 13: Cancer registration rate over time and by geographical area.

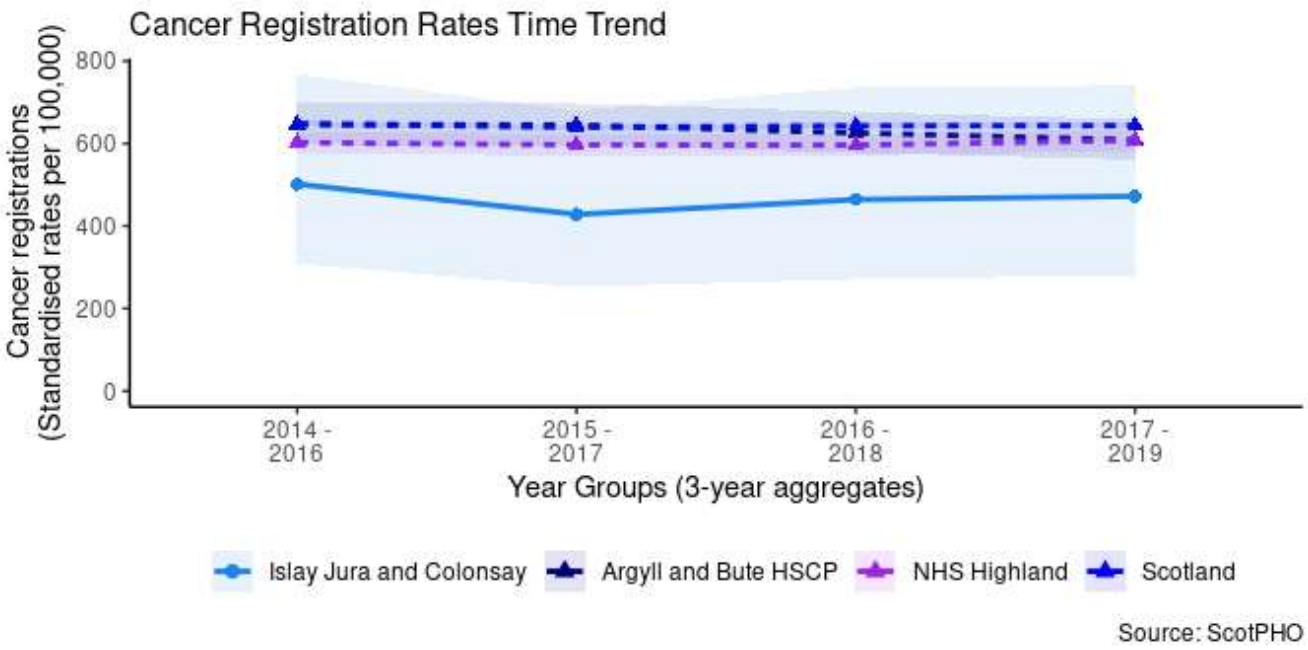
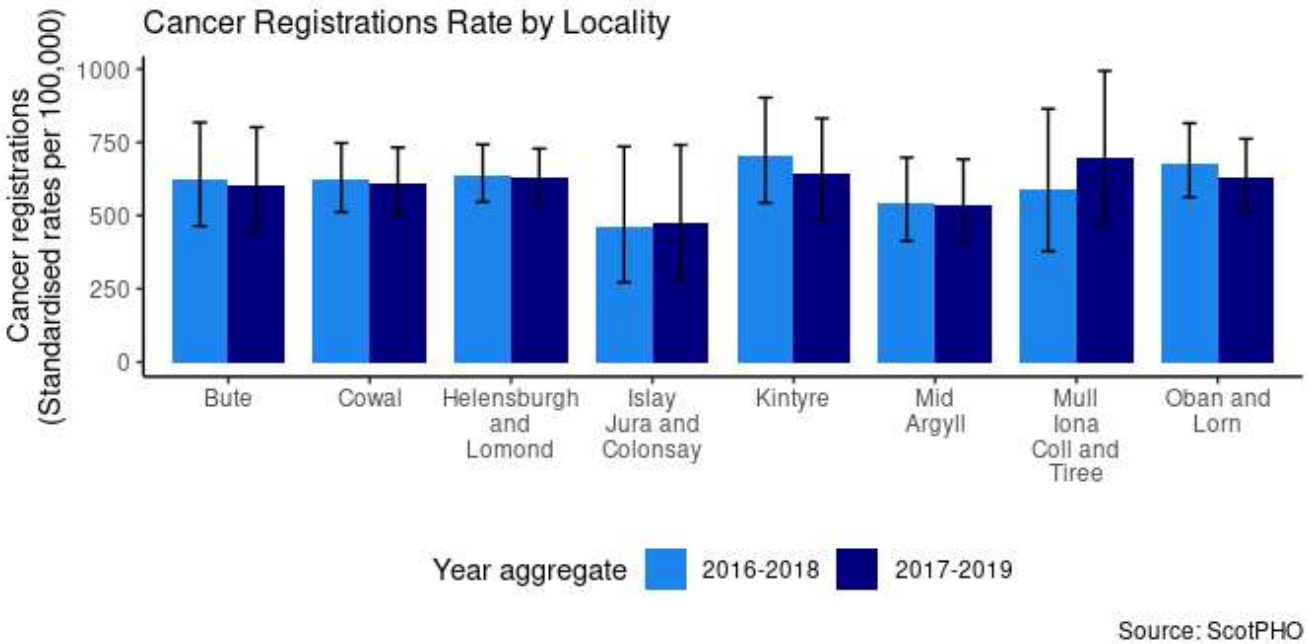


Figure 14: Cancer registration rates in Argyll and Bute HSCP localities.



Anxiety, Depression, and Psychosis Prescriptions

In the 2019/20 financial year, 23.85% of people were prescribed medication for anxiety, depression, or psychosis (ADP) in Islay Jura and Colonsay Locality. This is a 4.1% increase from the previous financial year. Differences over time and between areas may relate to multiple factors, only one of which is underlying disease. Note that data are based on main original licensed use for the prescriptions and some drugs included may be prescribed for other purposes.

Figure 15: Percentage population prescribed ADP medication in Argyll and Bute HSCP localities.

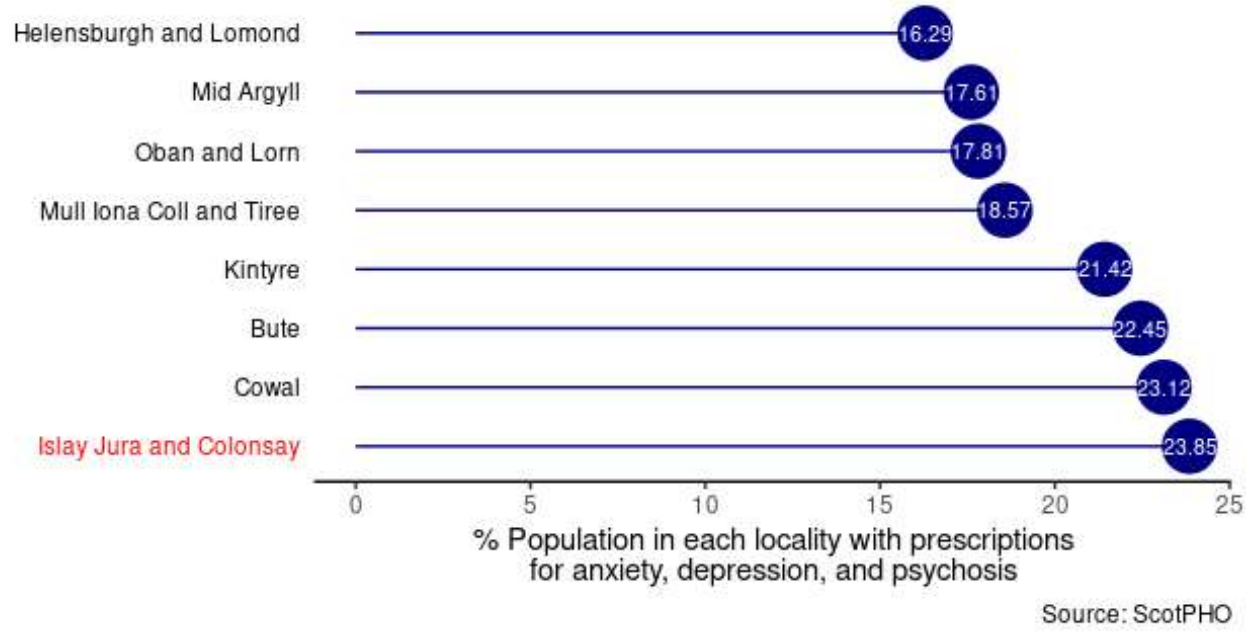
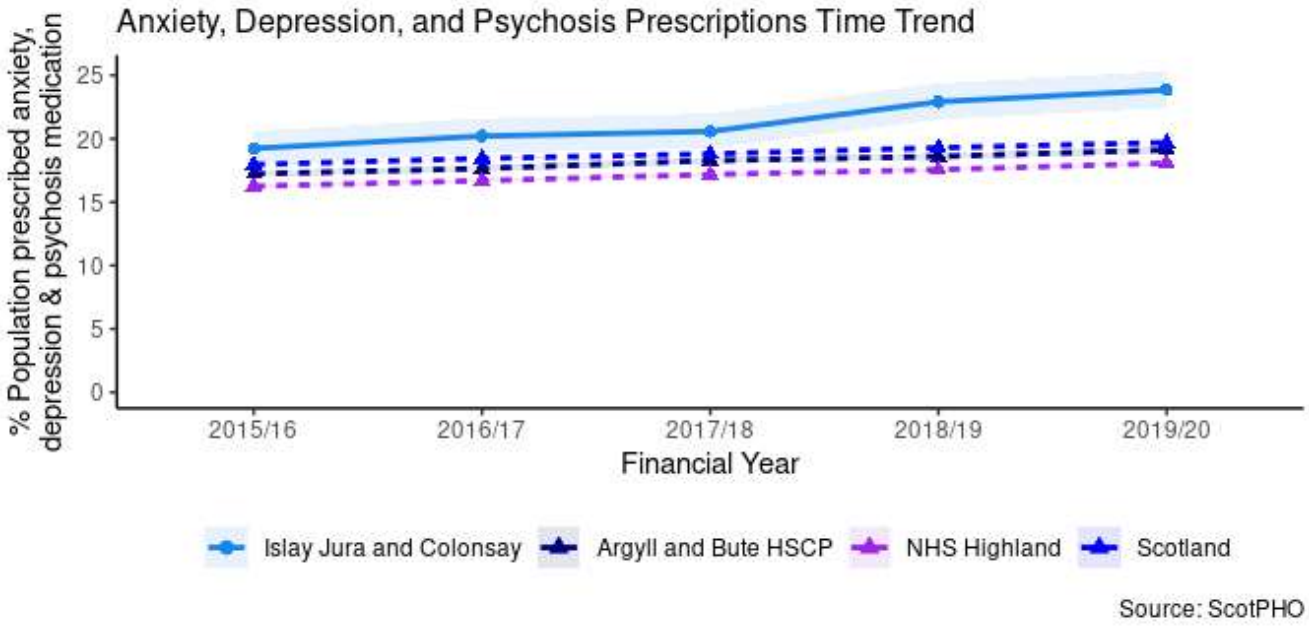


Figure 16: ADP prescriptions over time and by geographical area.



Behavioural Factors

Summary:

Mental and physical wellbeing has close ties with people's behaviours. Life circumstances including financial security, employment and location are interlinked with behavioural factors. This section provides data on drug-related hospital admissions, alcohol-related hospital admissions, alcohol-specific mortalities and bowel screening uptake, to give an overview of some behaviours known to be associated with health and wellbeing outcomes.

For the most recent time periods available[3], Islay Jura and Colonsay had:

- **18** drug-related hospital admissions per 100,000 age-sex standardised population[4]. This is a lower rate of admissions than for Scotland (221).
- **726** alcohol-related hospital admissions per 100,000 age-sex standardised population[4].
- **28** alcohol-specific mortalities per 100,000 age-sex standardised population[4].
- a **69%** uptake of bowel cancer screening for the eligible population.

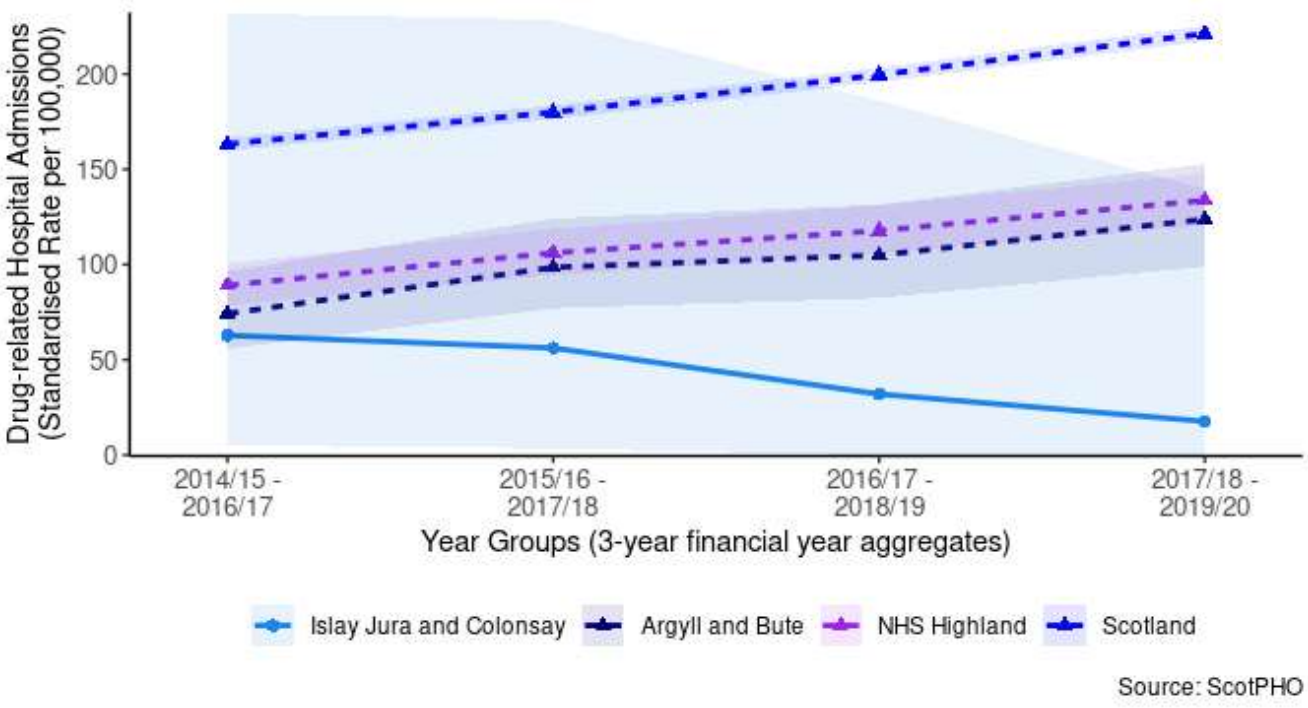
Drug-related Hospital Admissions

There were 18 drug-related hospital admissions per 100,000 age-sex standardised population[4] in Islay Jura and Colonsay locality for the most recent time period available (3 year financial year aggregate for 2017/18 - 2019/20).

This is a -71% decrease since 2014/15 - 2016/17 (3 financial year aggregates).

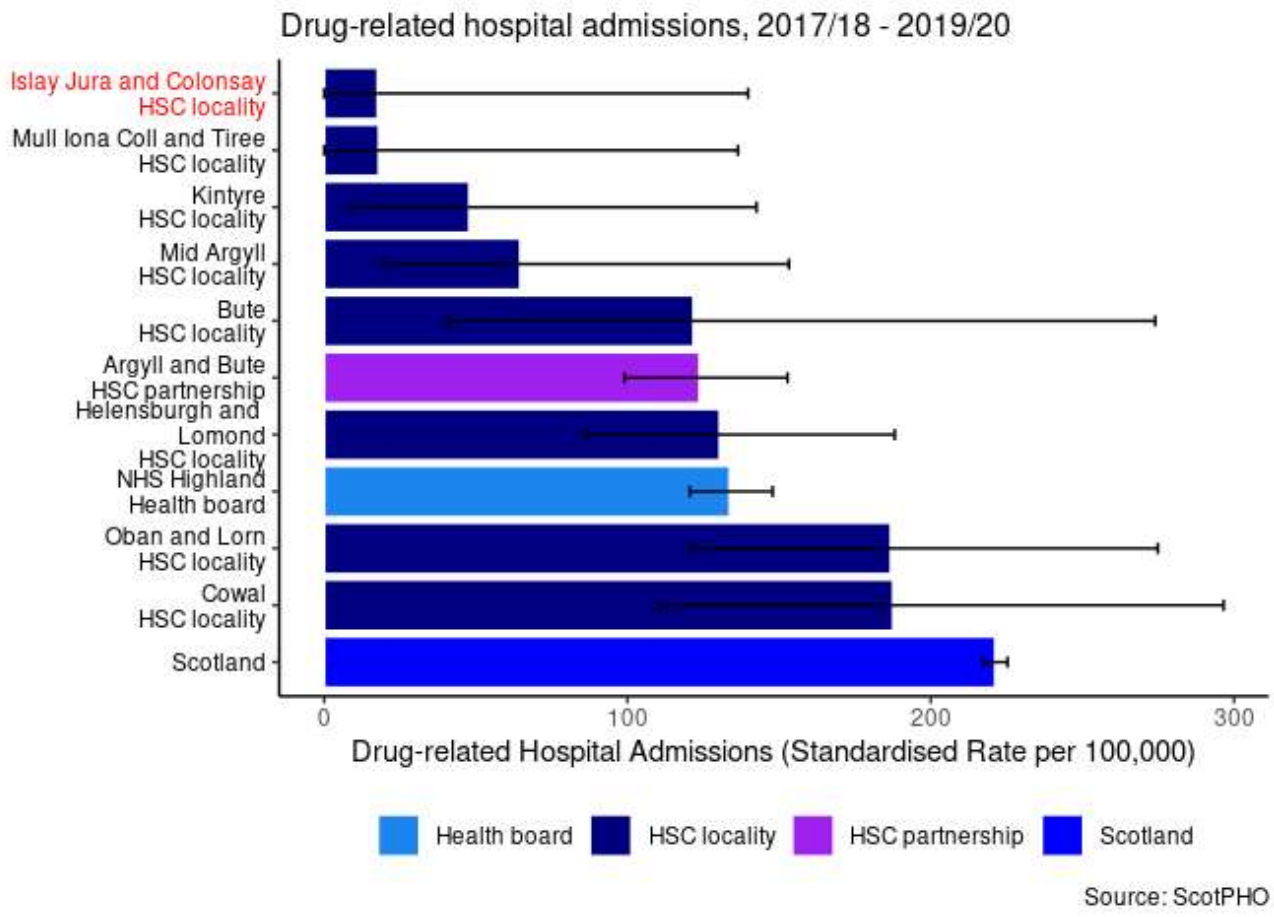
A trend of the change in drug-related hospital admissions for Islay Jura and Colonsay locality compared with Scotland, Argyll and Bute HSCP and NHS Highland is shown in the chart below from 2014/15 - 2016/17 onwards.

Figure 17: Trend of Drug-related Hospital Admission Rates by geographical area.



A comparison of areas at the most recent time period (2017/18 - 2019/20 aggregated financial years) is available below. This shows Islay Jura and Colonsay locality has a lower rate of admissions (18) than Argyll and Bute Partnership (124), and a lower rate of admissions than Scotland (221) overall.

Figure 18: Comparison of Drug-related Hospital Admission Rates for the period 2017/18 - 2019/20.

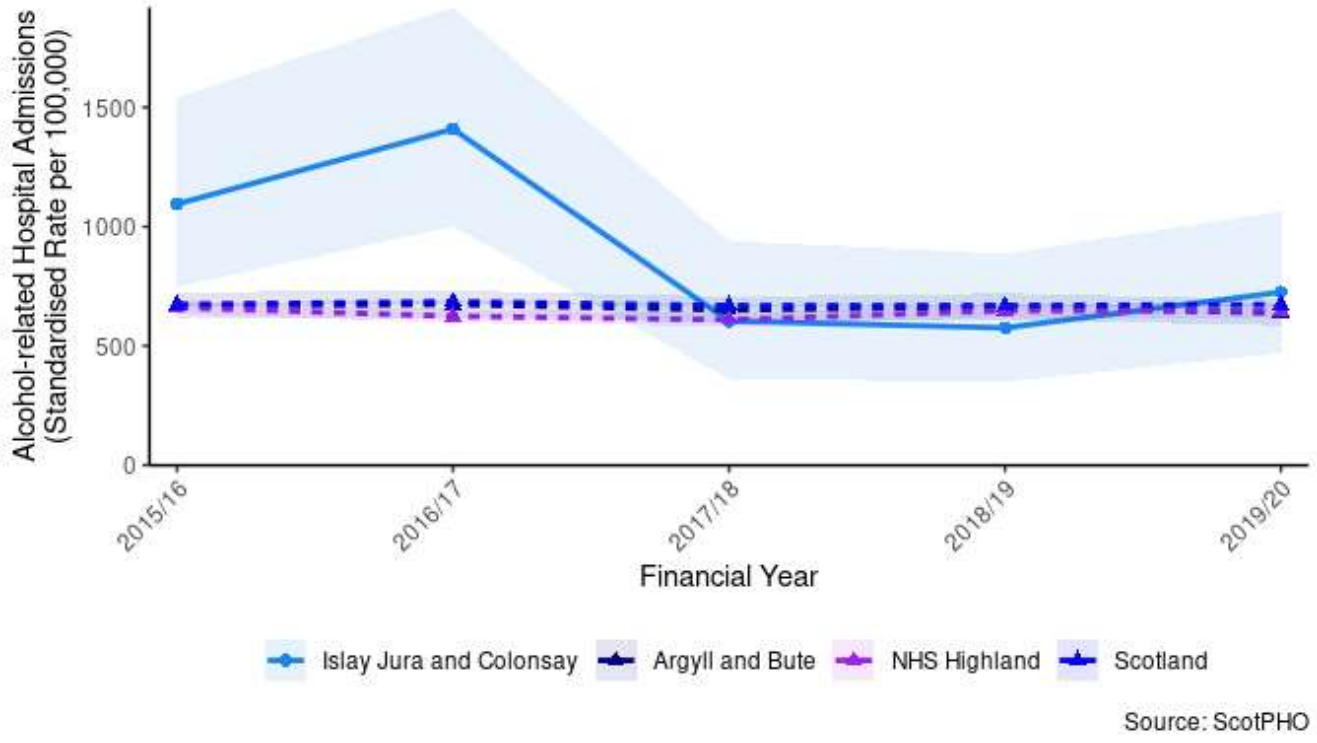


Alcohol-related Hospital Admissions

The 2019/20 alcohol-related admissions rate is 726 per 100,000 age-sex standardised population[4], which is a 34% decrease overall since 2015/16.

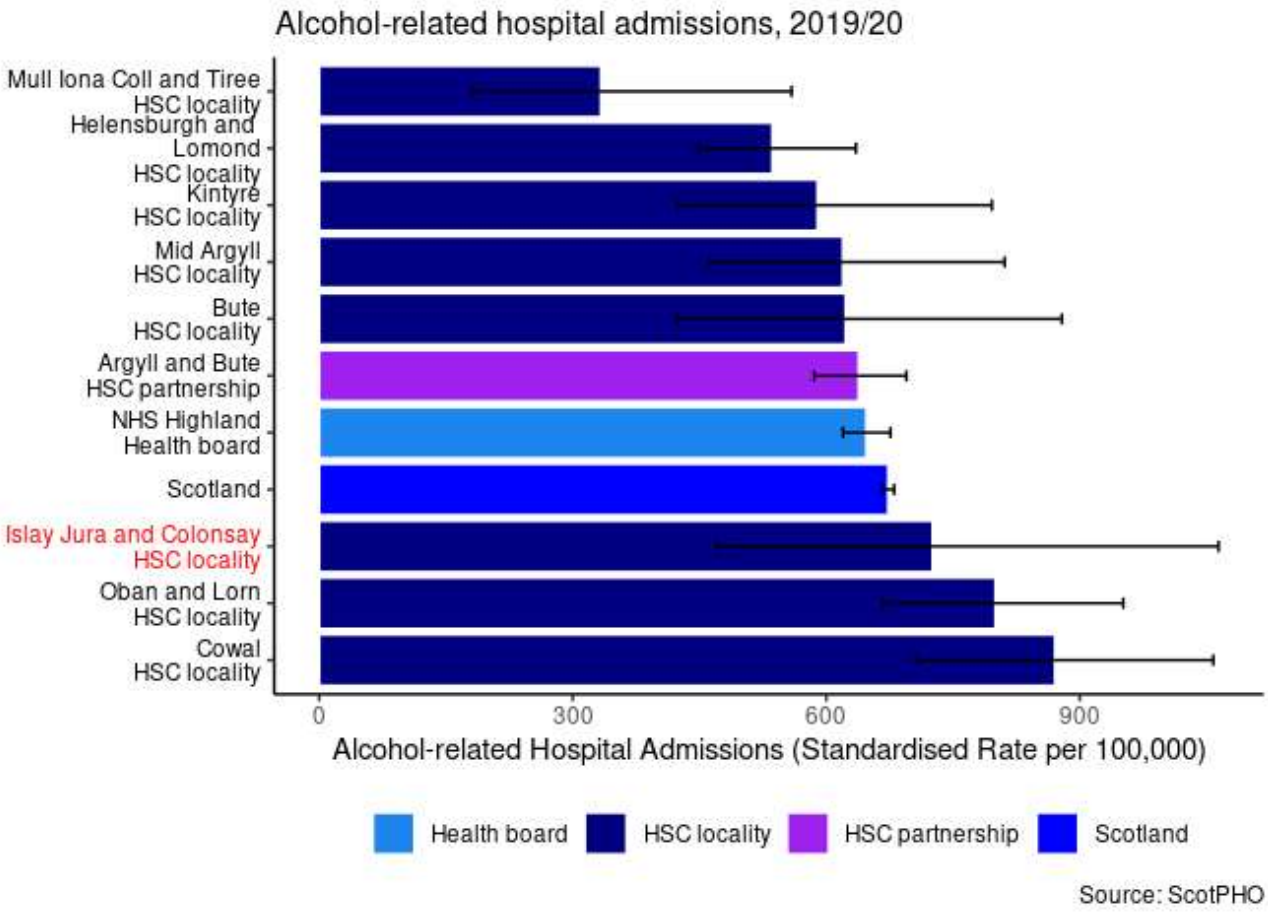
The chart below shows a trend of alcohol-related hospital admissions for Islay Jura and Colonsay locality compared with Scotland, Argyll and Bute Partnership and NHS Highland from financial year 2015/16 to 2019/20.

Figure 19: Trend of Alcohol-related Hospital Admission Rates by geographical area.



Comparison across different areas for 2019/20 is shown in Figure 20. This shows that Islay Jura and Colonsay locality had a higher alcohol-related hospital admissions rate (726) compared to Scotland (673).

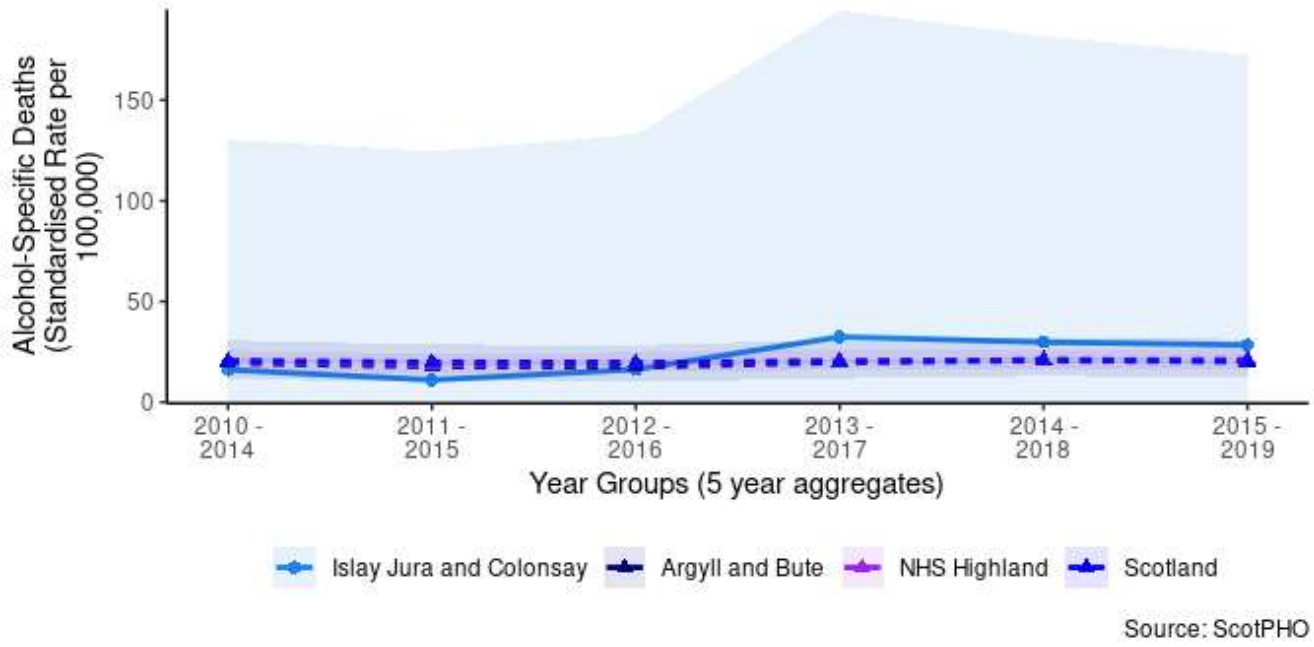
Figure 20: Comparison of Alcohol-related Hospital Admission Rates for 2019/20.



Alcohol-Specific Deaths

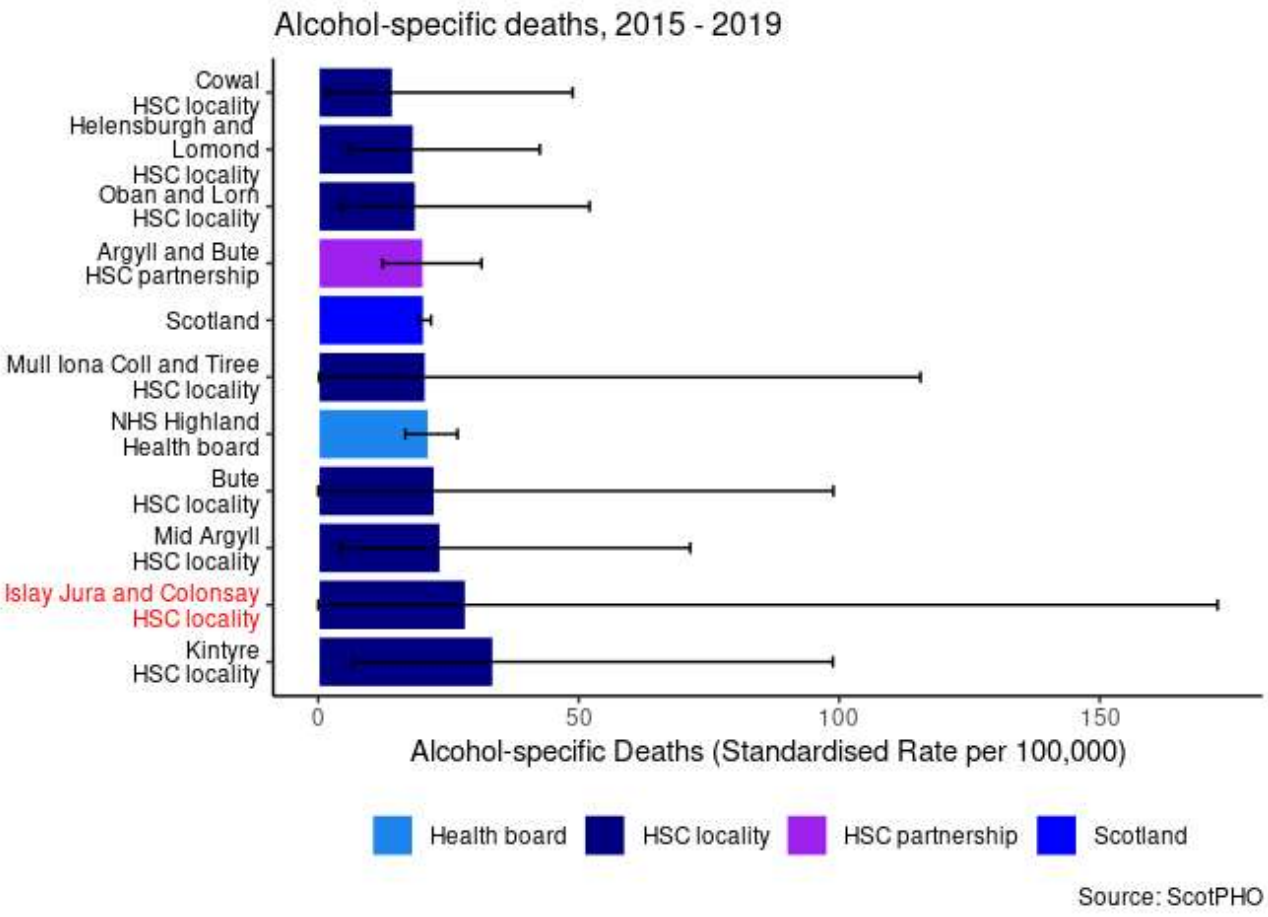
Data on alcohol-specific deaths is available as 5 year aggregates. The rate of alcohol-specific deaths is currently higher in Islay Jura and Colonsay than the rate in 2010 - 2014 (77% change).

Figure 21: Trend of Alcohol-Specific Death Rates by geographical area.



A comparison across different areas illustrates that Islay Jura and Colonsay locality has a higher alcohol-specific death rate compared to Scotland as a whole.

Figure 22: Comparison of Alcohol-related Death Rates for the period 2015 - 2019 (5 year aggregate).

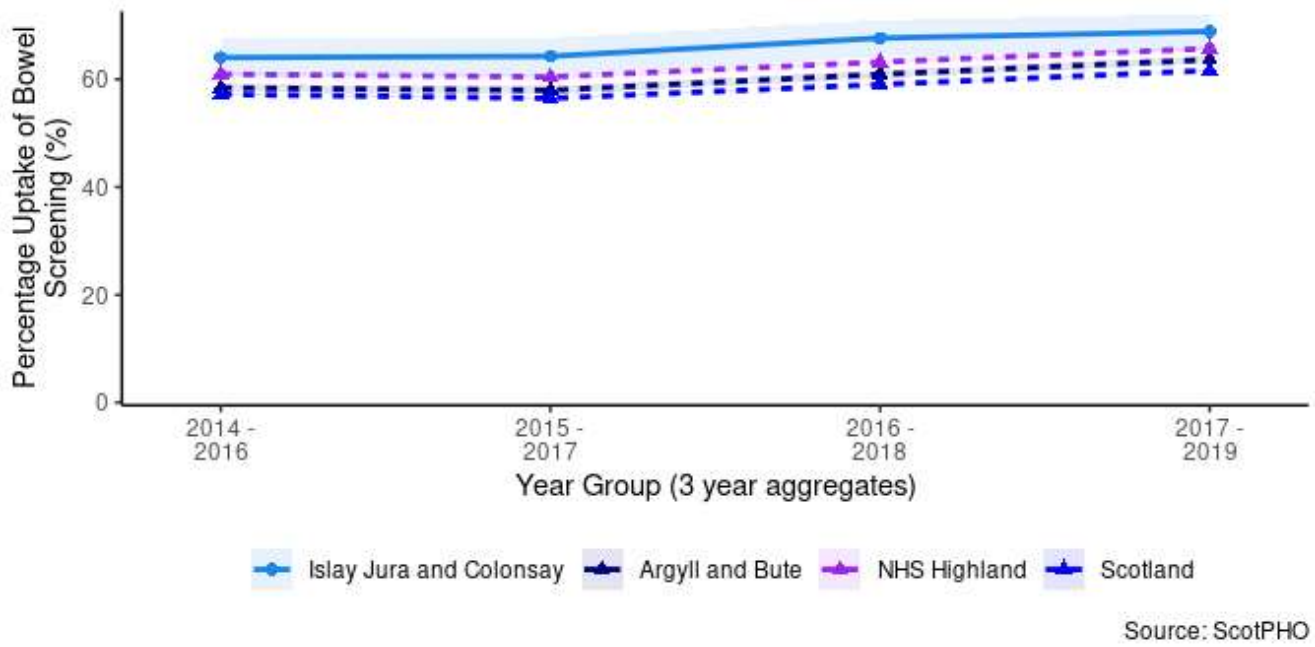


Bowel Screening Uptake

Bowel screening is offered every two years to eligible men and women aged between 50-74 years old. Eligible people are posted a test kit which is completed at home. Since 1st April 2013, those aged 75 and over can also self-refer and opt into screening.

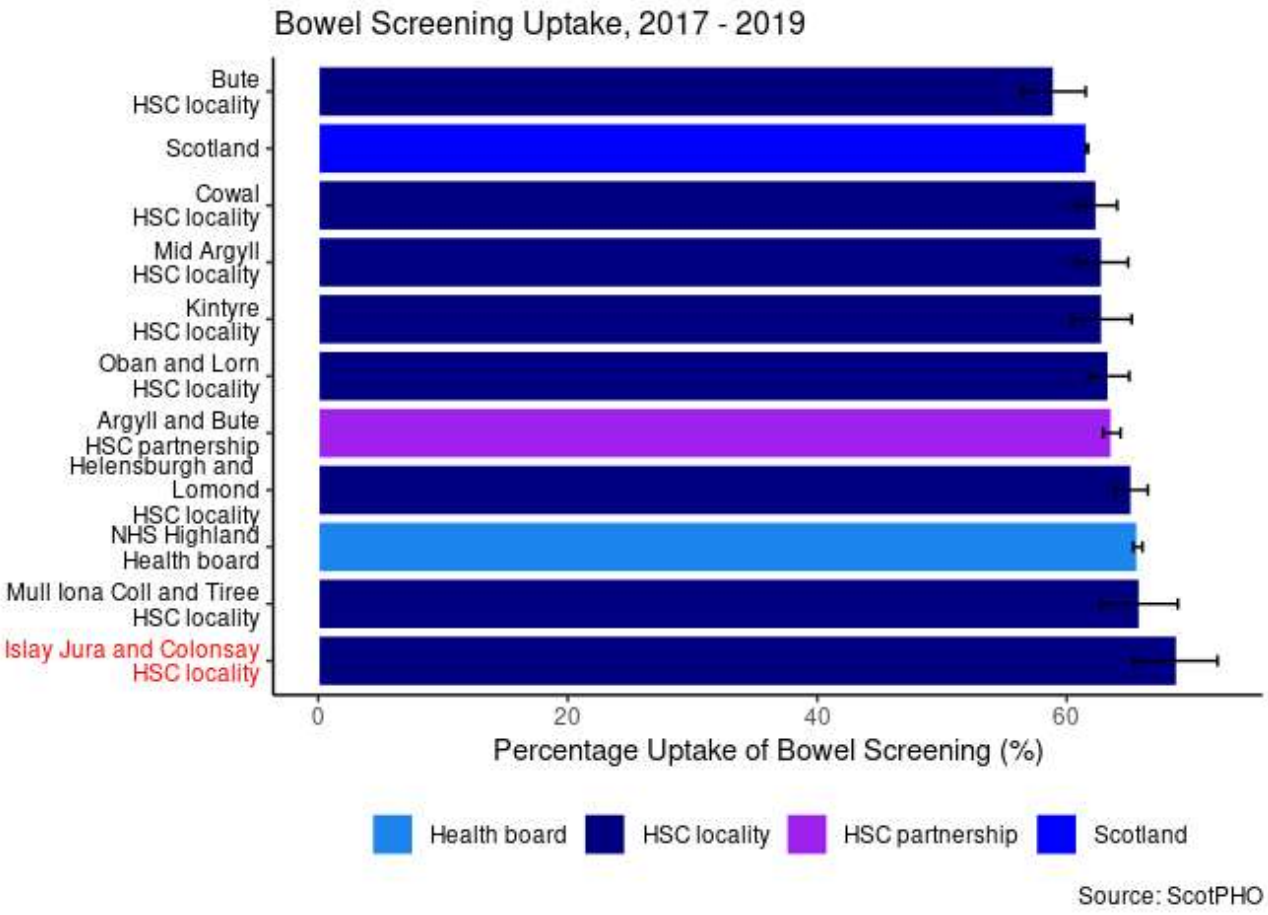
A trend of the percentage uptake of bowel screening among the eligible population is shown below for Islay Jura and Colonsay locality compared with Scotland, Argyll and Bute HSCP and NHS Highland. Data is suppressed into 3 year aggregates. The 2017 - 2019 uptake rate for Islay Jura and Colonsay is **69%**.

Figure 23: Trend of Bowel Screening Uptake for eligible men and women, by geographical area.



Compared with Scotland, Islay Jura and Colonsay locality has a higher percentage uptake of bowel cancer screening for the period 2017 - 2019.

Figure 24: Comparison of Bowel Screening Uptake for 2017 - 2019.



Hospital and Community Care

This section includes acute hospital data, delayed discharge bed days and A&E attendances. Please note that for 2020 onwards, hospital activity would have been severely affected by the COVID-19 pandemic. Information on how this has had a wider impact is provided in Footnote 6 at the end of the document.

For the most recent time periods available, Islay Jura and Colonsay had:

- **7,959** emergency hospital admissions per 100,000 population.
- **65,592** unscheduled acute specialty bed days per 100,000 population.
- **2,751** A&E attendances per 100,000 population.
- **6,728** delayed discharge bed days per 100,000 population.
- **1154** emergency hospital admissions from falls per 100,000 population.
- **66** emergency readmissions (28 day) per 1,000 discharges.
- **740** potentially preventable hospital admissions per 100,000 population.
- People on average spent **93%** of their last 6 months of life in a community setting.

Emergency Admissions

Figure 25: Emergency admissions by age group

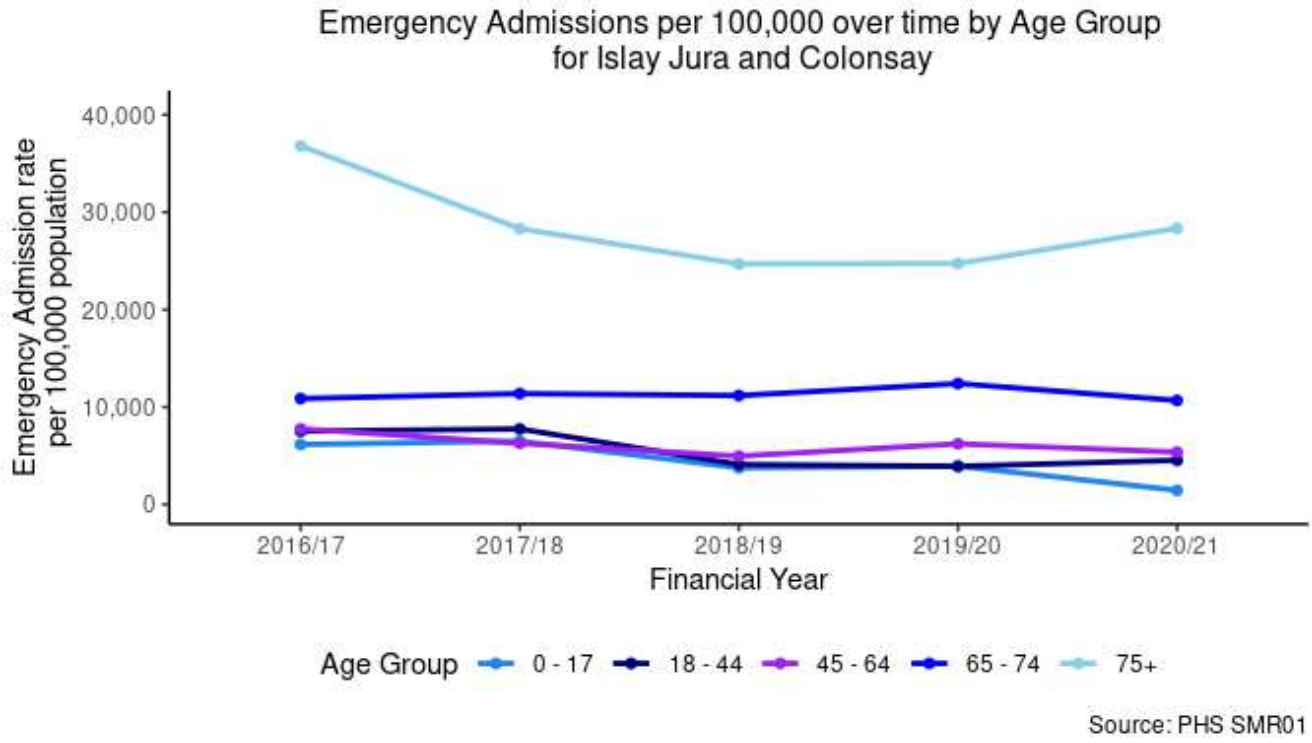
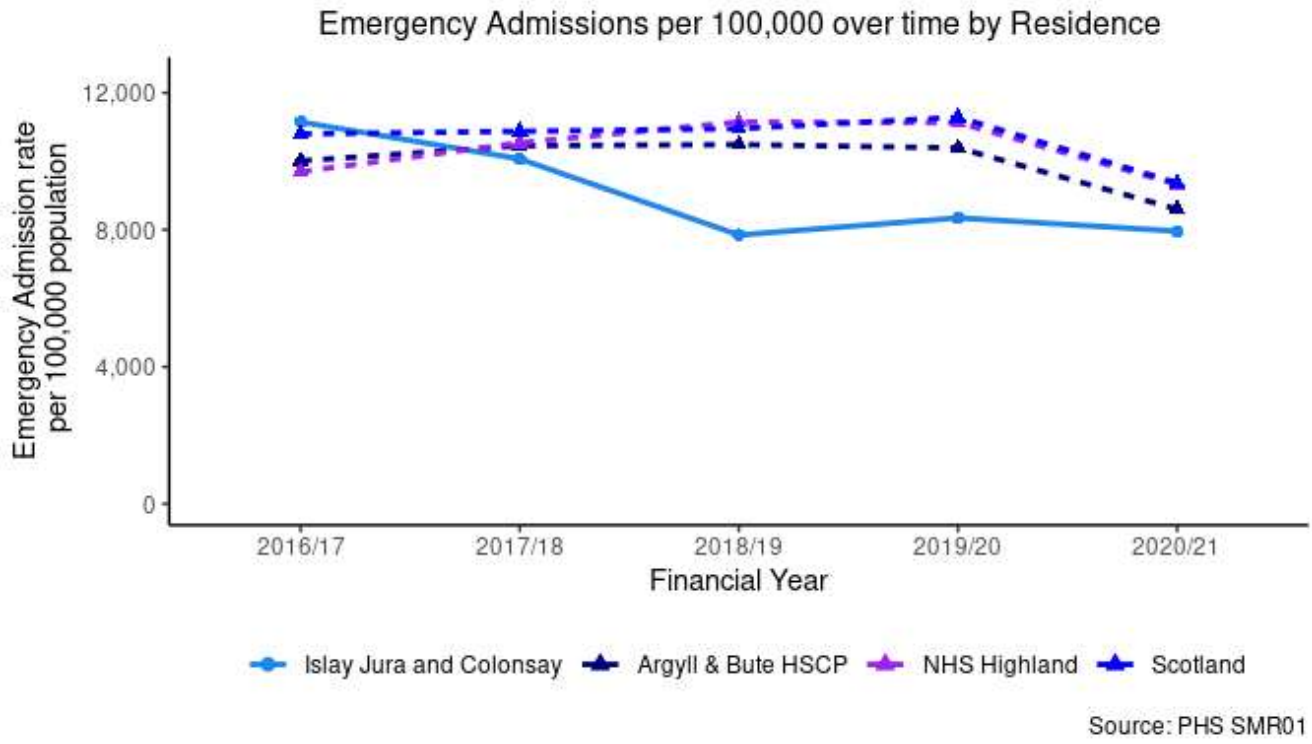


Figure 26: Emergency admissions by geographical area



Unscheduled Acute Bed Days

Figure 27: Unscheduled bed days by age group

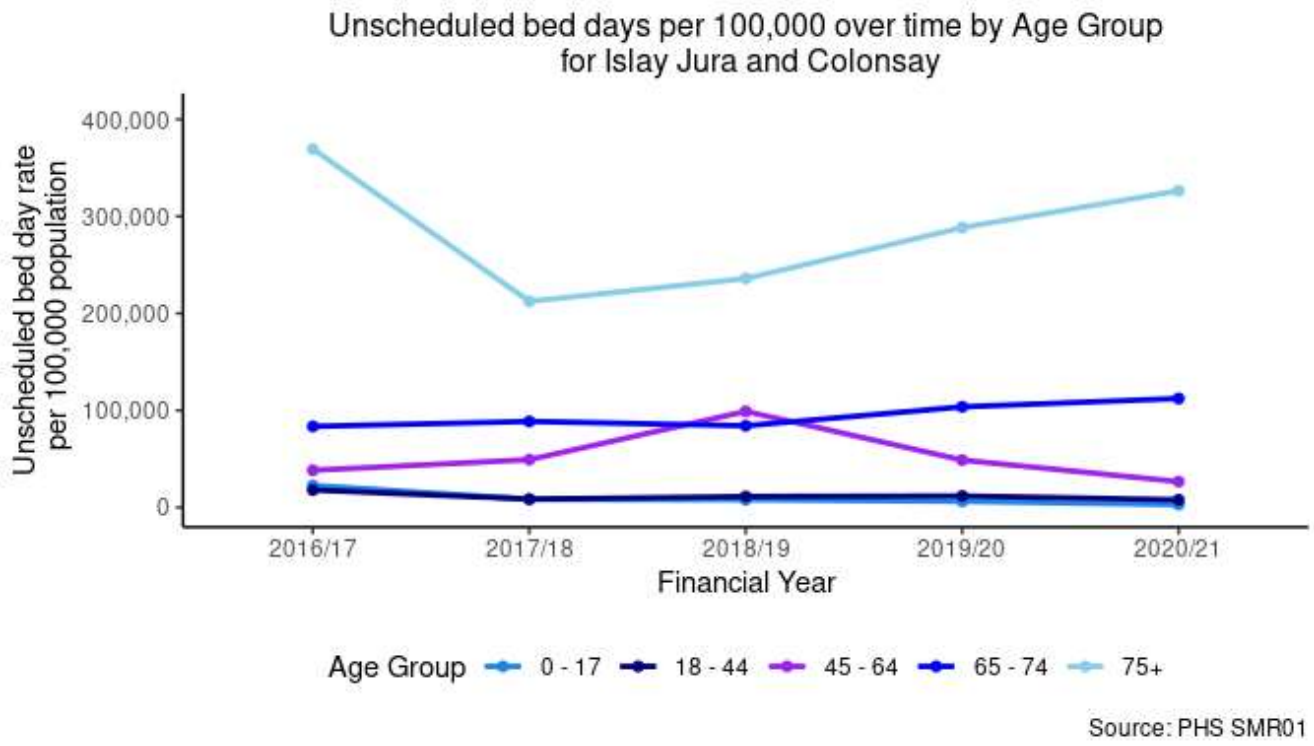
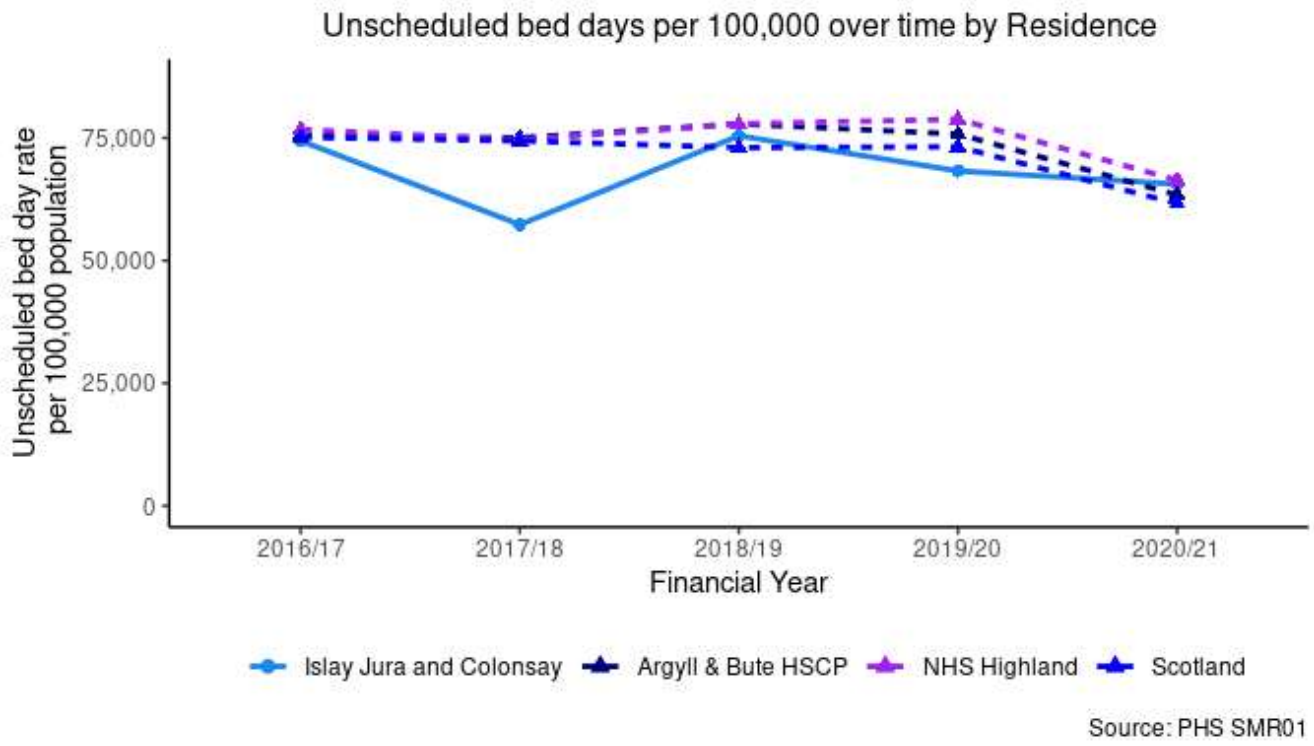
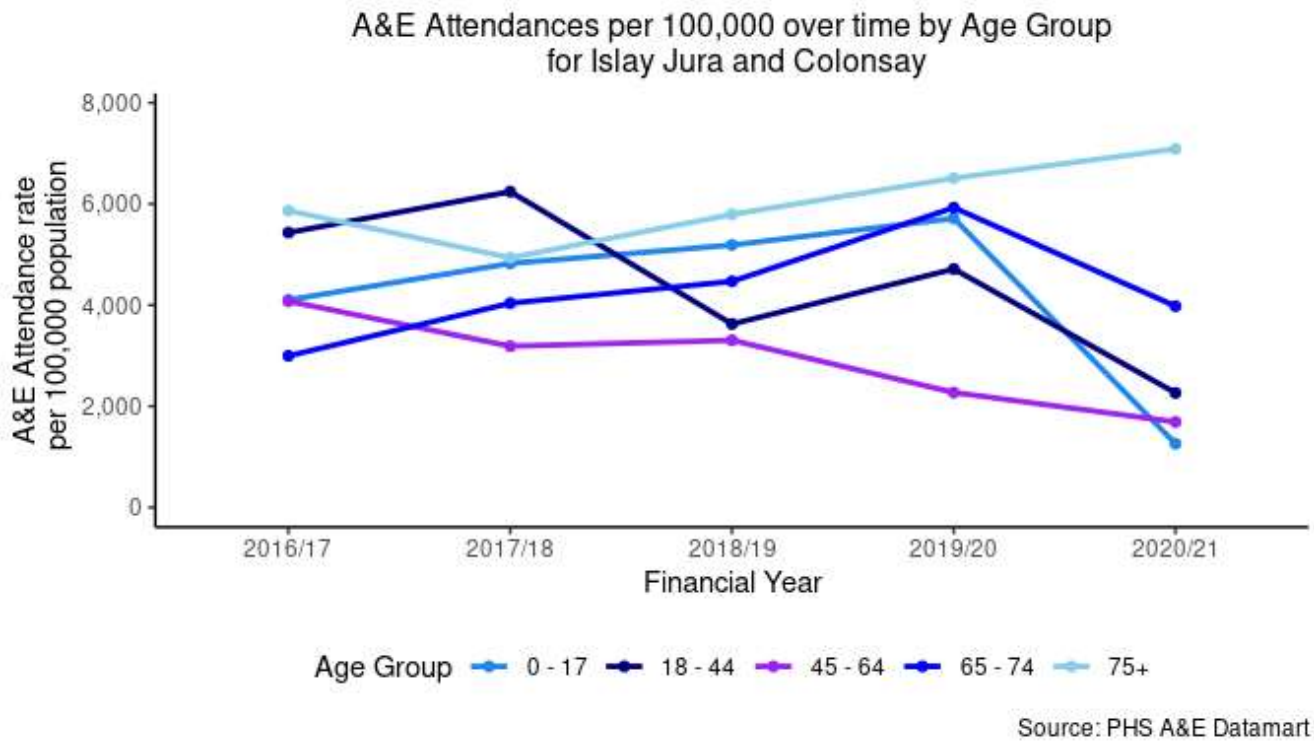


Figure 28: Unscheduled bed days by geographical area



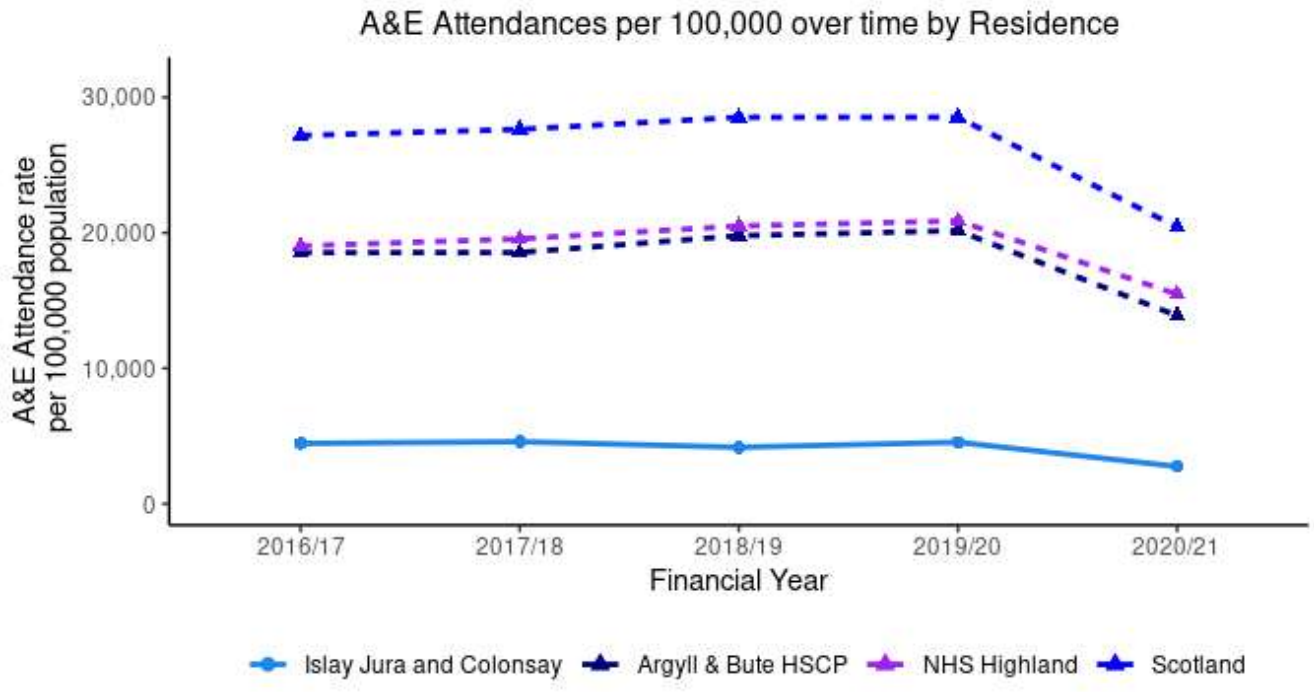
A&E Attendances

Figure 29: A&E attendances by age group



Source: PHS A&E Datamart

Figure 30: A&E attendances by geographical area



Source: PHS A&E Datamart

Delayed Discharge Bed Days

Figure 31: Delayed discharge bed days by age group

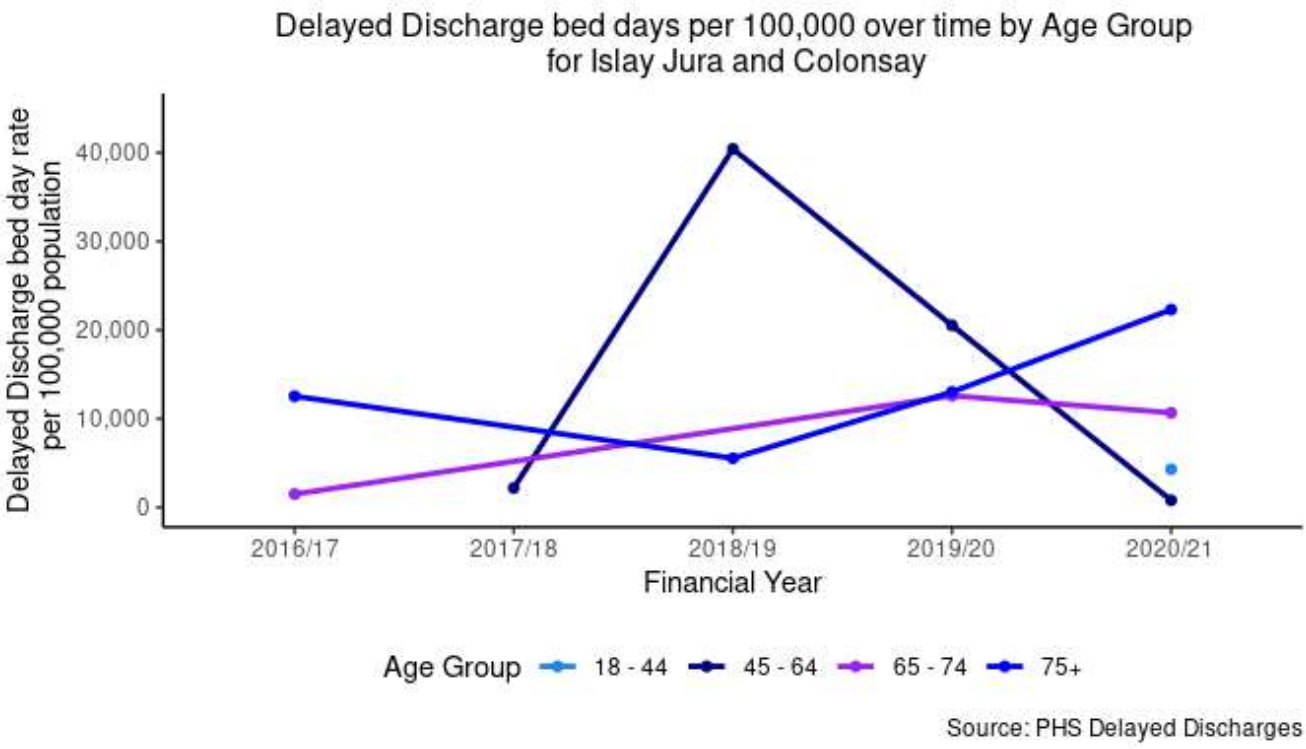
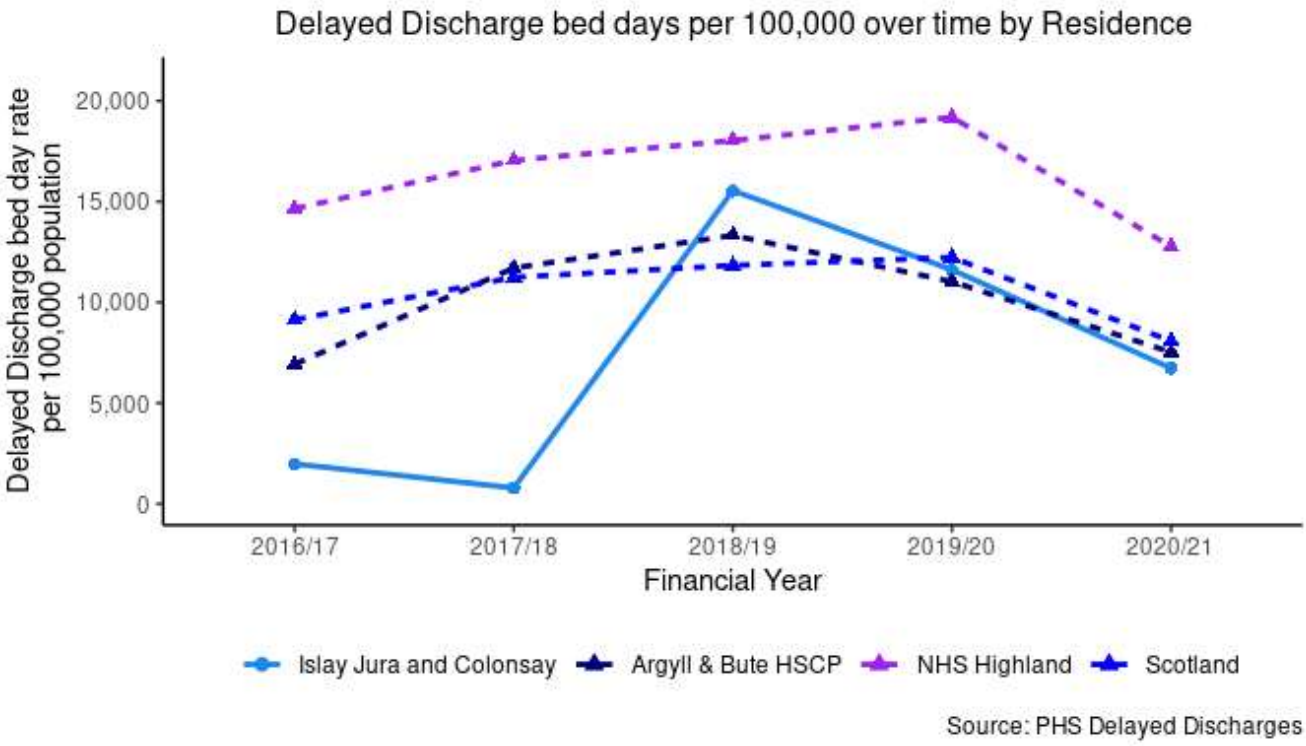
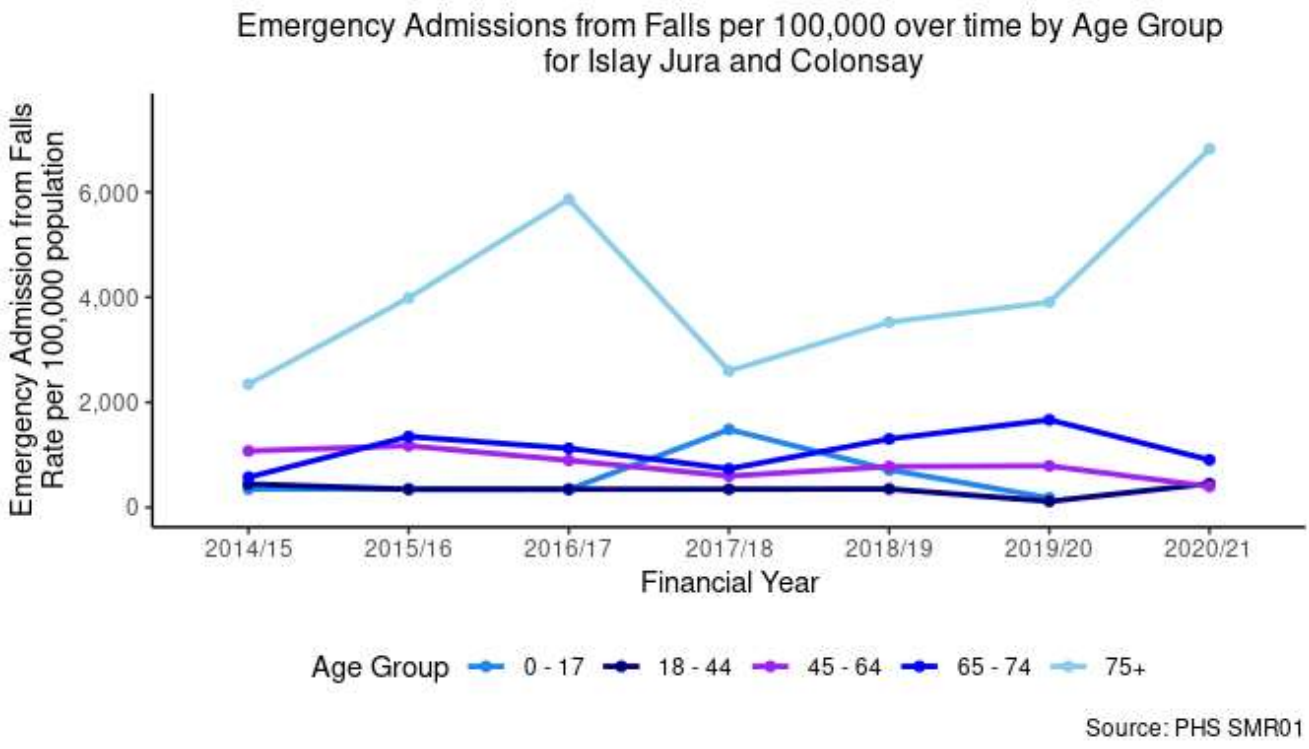


Figure 32: Delayed discharge bed days by geographical area



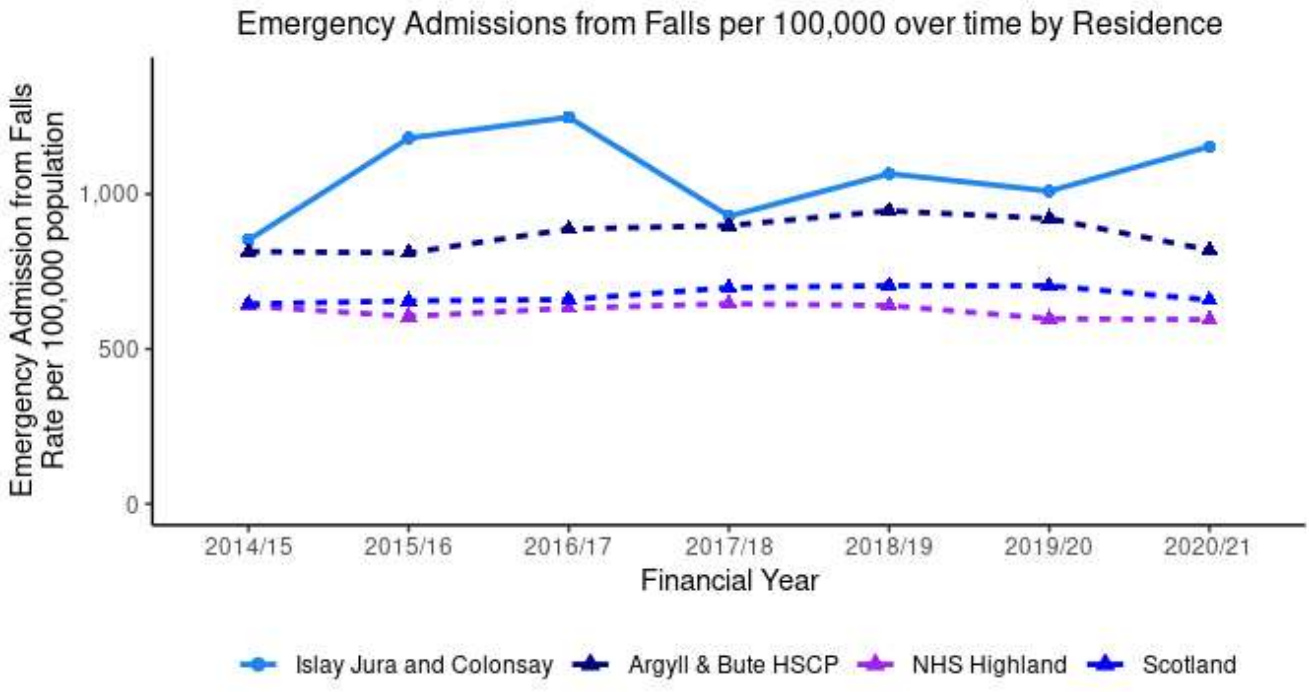
Emergency Admissions from a Fall

Figure 33: Falls by age group



Source: PHS SMR01

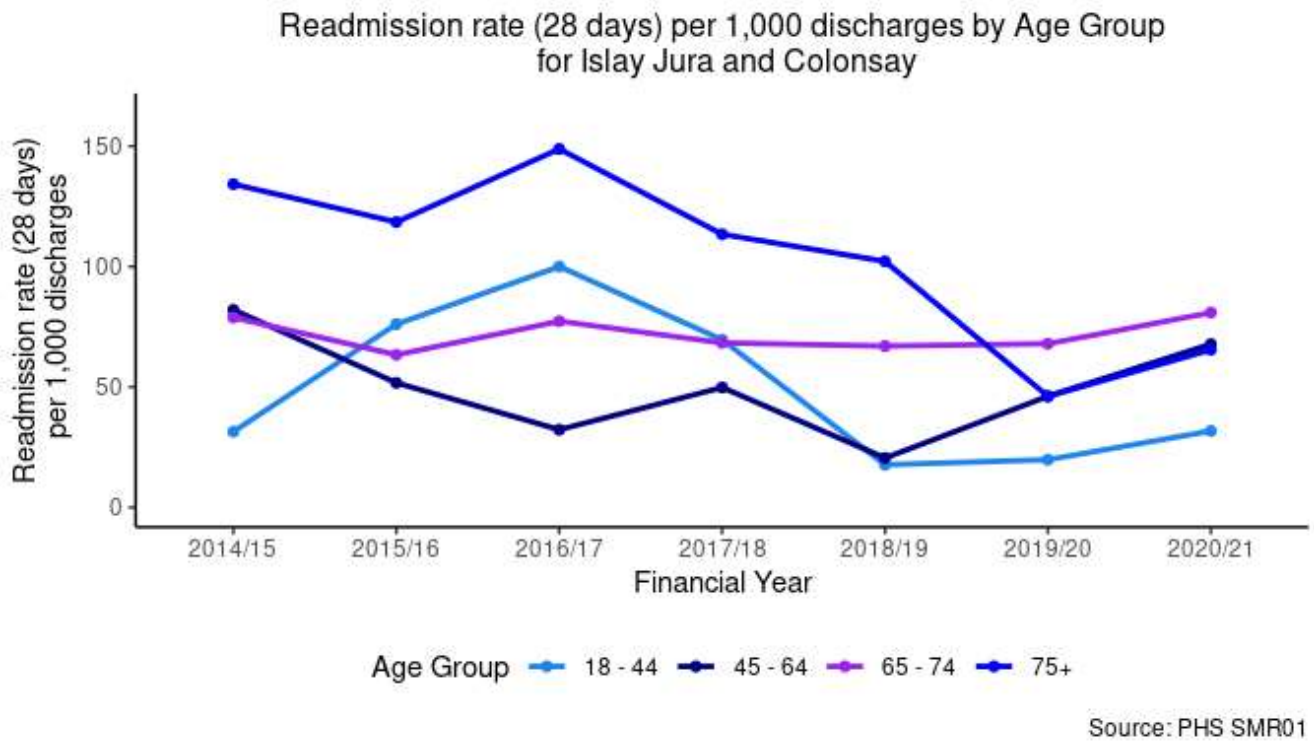
Figure 34: Falls by geographical area



Source: PHS SMR01

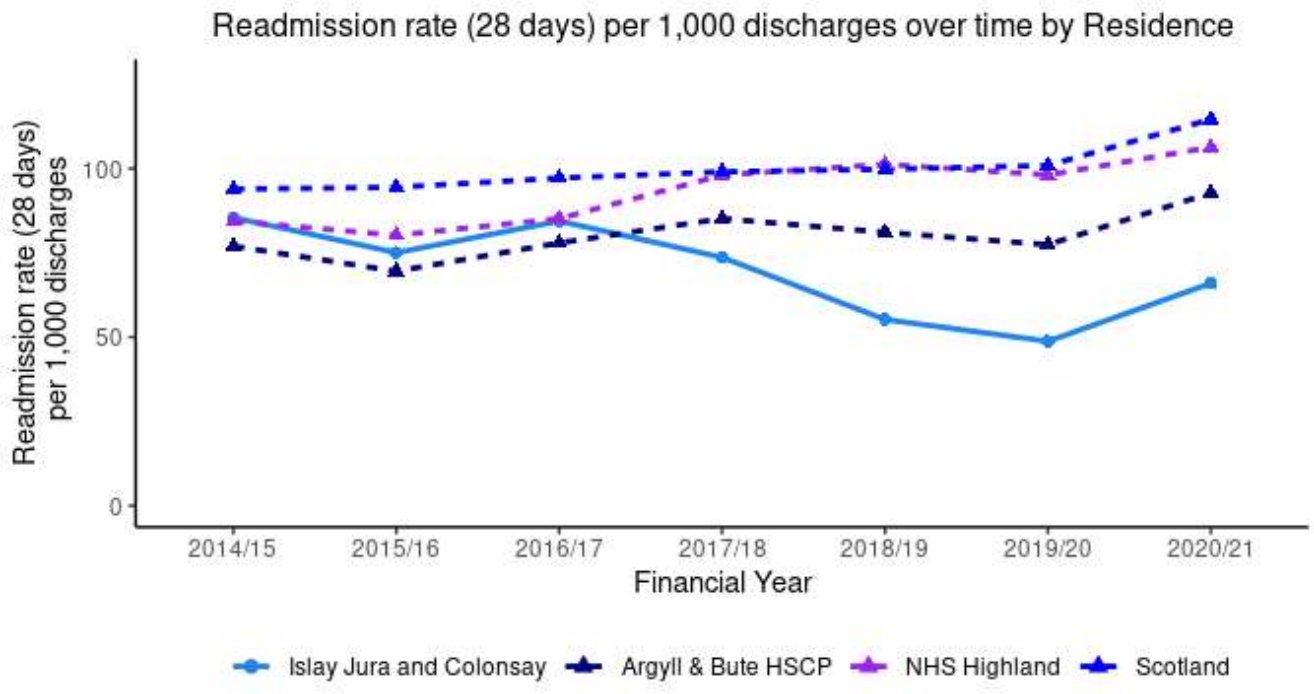
Emergency Readmissions (28 days)

Figure 35: Emergency readmissions by age group



Source: PHS SMR01

Figure 36: Emergency readmissions by geographical area

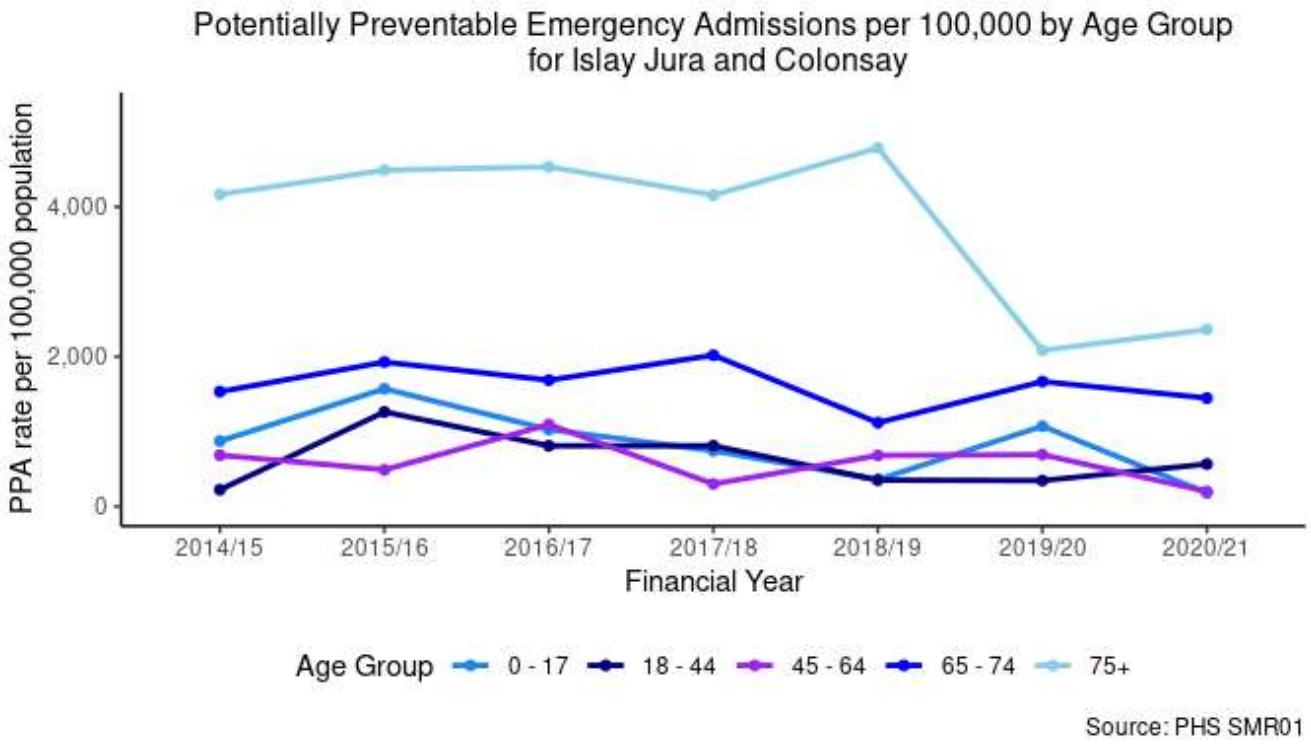


Source: PHS SMR01

Potentially Preventable Admissions (PPAs)

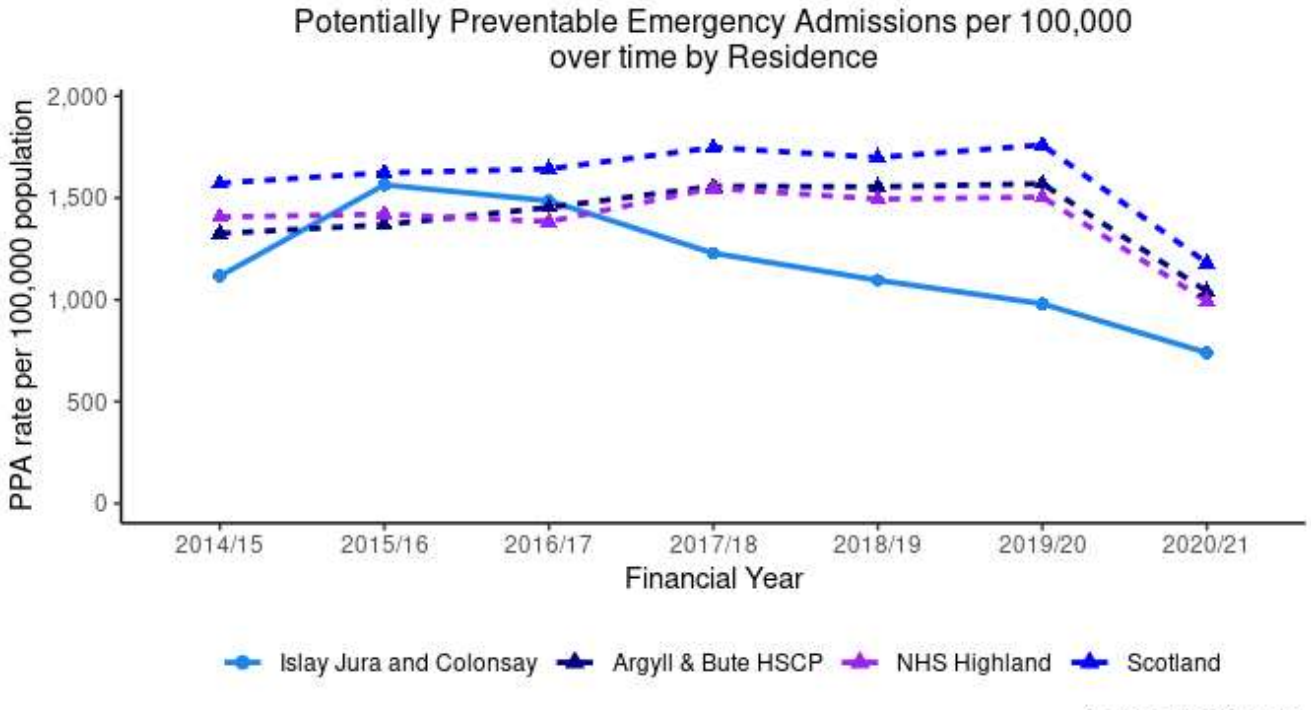
Information on which conditions are counted as PPAs is available in Appendix 3 in the accompanying summary document.

Figure 37: PPAs by age group



Source: PHS SMR01

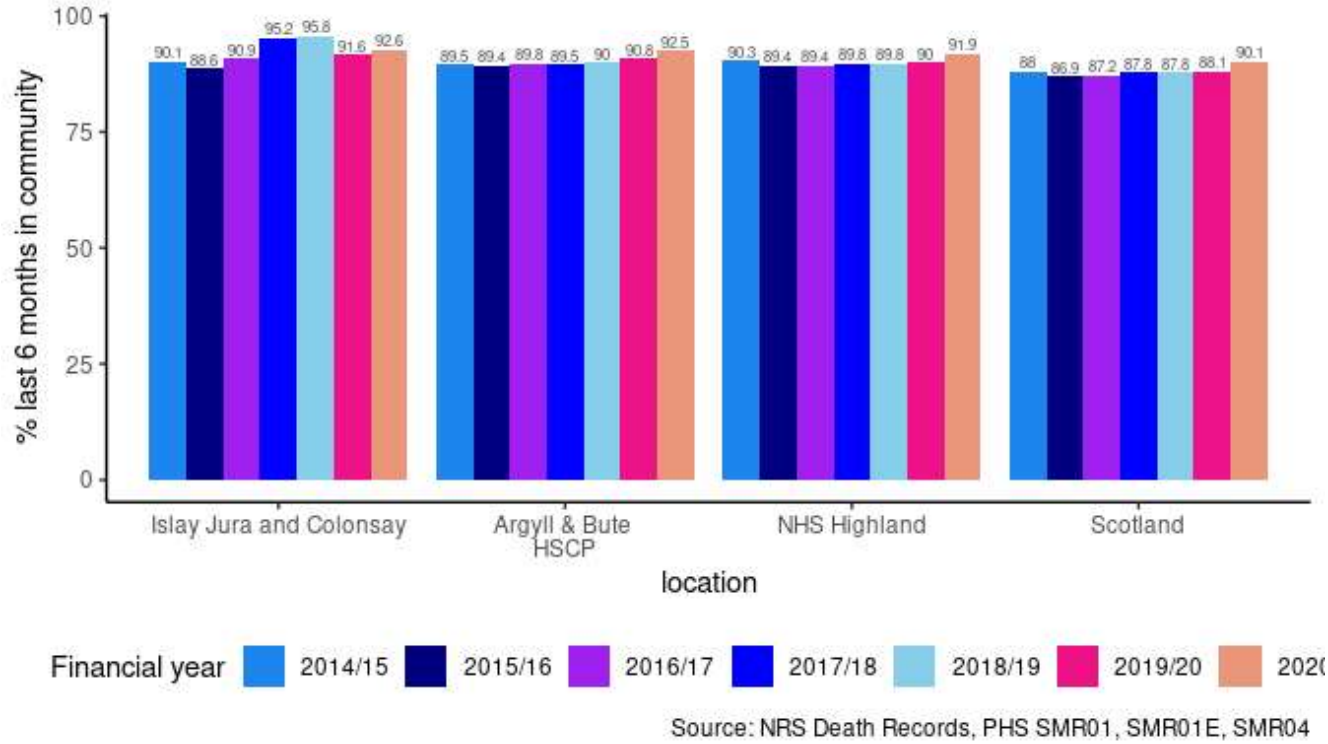
Figure 38: PPAs by geographical area



Source: PHS SMR01

% Last 6 months in a Community Setting

Figure 39: Last 6 months in a community setting by geographical area



Source: NRS Death Records, PHS SMR01, SMR01E, SMR04

Footnotes

1. Population projections are not currently provided by NRS at the locality level. To explore how the population in Islay Jura and Colonsay is expected to change in the future, the percent changes in population projection to 2025 for Argyll and Bute by age group and gender were calculated from the NRS Local Authority Population Projections. These percent changes were then applied to the Islay Jura and Colonsay 2018 mid-year population estimates (also split by age group and gender) to obtain population projection estimates for Islay Jura and Colonsay, based on the projections for the HSCP and the current population structure of the locality.
2. Care Home Data included in the Services Map and Table was sourced from the Care Inspectorate. GP Practice data from October 2021, and Hospital and A&E data was sourced from Public Health Scotland Open Data. Only services that are within the physical boundary of the HSCP or Locality are included in the map and table, so there may be services outside Argyll and Bute which people may use but are not shown.
3. The data used in General Health and Behavioural Factors sections (except for long-term conditions) of this locality profile are taken from ScotPHO. There may be more recent data available for the indicators elsewhere.
4. Data taken from ScotPHO is often reported using the European Age-Sex Standardised Rate per 100,000. This allows for comparisons across different areas to be made. For more information on how these rates are calculated, please refer to www.isdscotland.org/Products-and-Services/GPD-Support/Population/Standard-Populations/
5. Physical long-term conditions data comes from the Source Linkage Files, and the conditions are identified using ICD-9 and ICD-10 codes in the diagnosis fields. Please note that the Source Linkage Files data only contains information on people who have had contact with the NHS through either inpatient admissions, outpatient attendances, daycase attendances, A&E attendances or through prescribed items, the data does not show all service users in Scotland who have been diagnosed with an LTC as not all of these individuals will have used these services. Also note that LTC rates are based on an adjusted population indicator in the Source Linkage Files so that population sizes are closer to the official estimates.
6. The 2020 COVID-19 pandemic will have had an effect on the most recent data available. A dashboard has been created by PHS which show the wider impacts of COVID-19 over many areas. You can access this here: https://scotland.shinyapps.io/phs-covid-wider-impact/

Locality Profile

Oban and Lorn Locality

October 2021

Table of Contents

Notes for this profile:

- All years shown are calendar years unless otherwise specified.
- Upper and lower 95% confidence intervals are shown throughout this document where available. In charts, these are displayed as shaded areas either side of trend lines, or as black error bars in bar charts. Confidence intervals show the range of possible values and a certainty that the true value falls within them.
- Definitions for the indicators shown are available in Appendix 1 in the accompanying summary document.
- Any zero figures for some indicators will indicate either suppression of small data or a complete lack of data available for this locality
- Data should be interpreted with caution, particularly for areas with relatively small population sizes where indicator data is expected, by chance alone, to have higher variation than in areas of larger population size. Note that differences between areas can relate to multiple factors including, for example, underlying rates of illness, rates of diagnosis and local differences in practice e.g. in data recording.

Demographics

Summary:

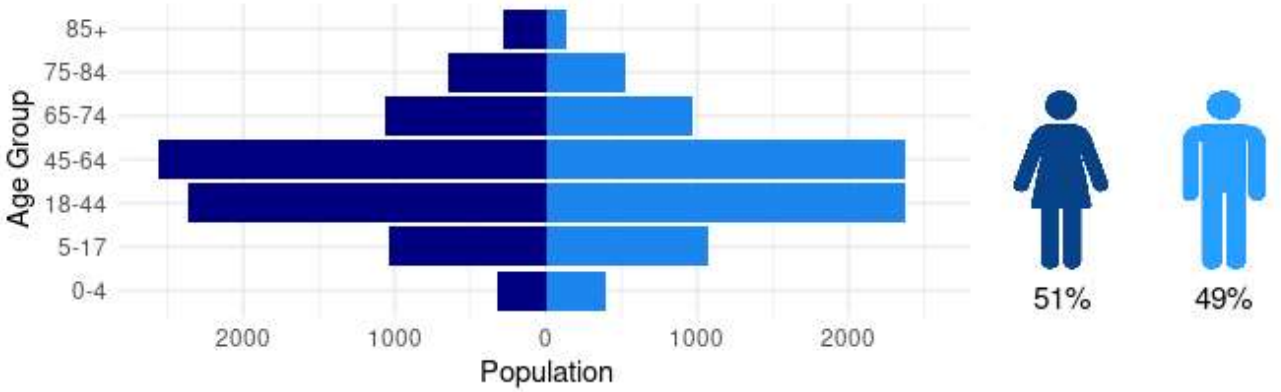
For the most recent time periods available, Oban and Lorn Locality had:

- A total population of **16,095** people, where **49%** were male, and **22%** were aged over 65.
- **0%** of people lived in the least deprived SIMD quintile, and **2.8%** lived in the most deprived quintile.

Population

In 2020, the total population of Oban and Lorn locality was 16,095. The graph below shows the population distribution of the locality.

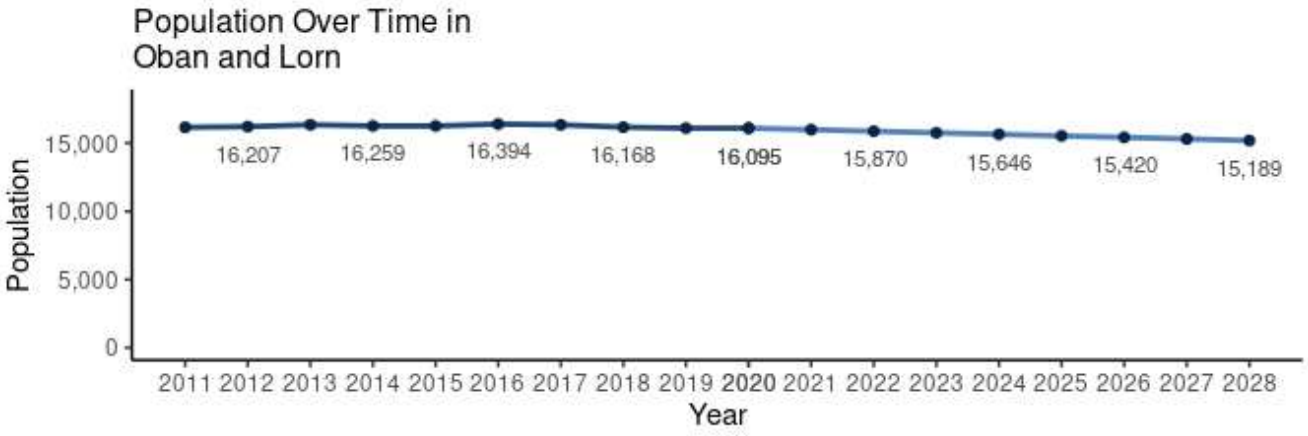
Figure 1: Population breakdown in Oban and Lorn.



Source: National Records Scotland

Figure 2 shows the historical population of Oban and Lorn, along with the NRS population projections. There is no significant linear trend in population. However, it has been falling since 2016. The population in Oban and Lorn is estimated to decrease by 3.5% from 2020 to 2025 *Please see the footnotes for more information on how the population projections were calculated*[1].

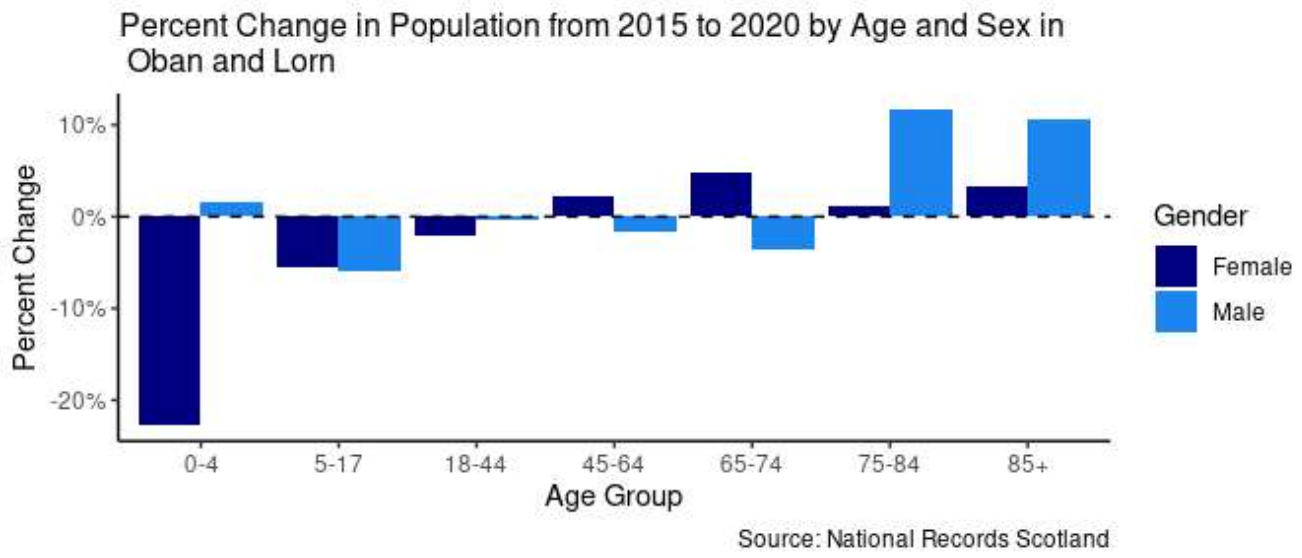
Figure 2: Population time trend and projection.



Source: National Records Scotland

Figure 3 shows how population structure has changed between 2015 and 2020.

Figure 3: Change in population structure over the last five years.



Deprivation

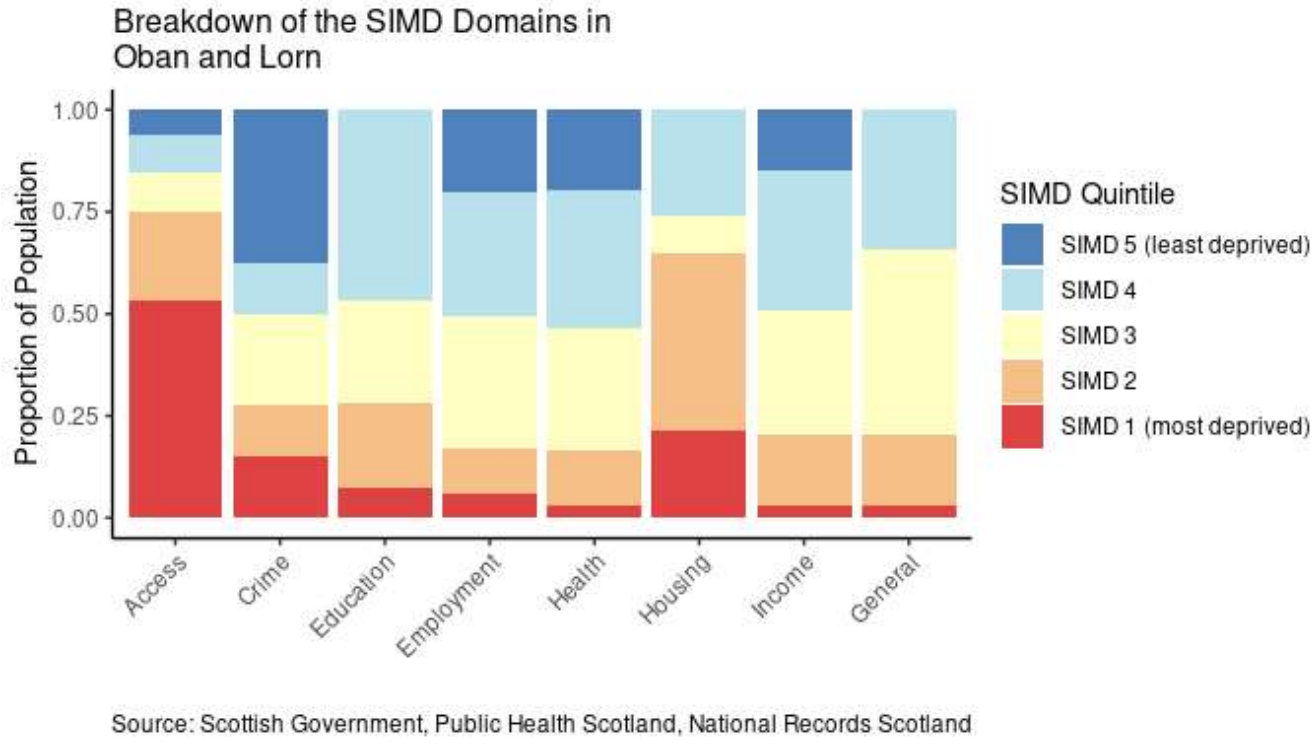
The following section explores the deprivation structure of Oban and Lorn through the Scottish Index of Multiple Deprivation (SIMD). The SIMD ranks all datazones in Scotland by a number of factors; Access, Crime, Education, Employment, Health, Housing and Income. Based on these ranks, each datazone is then given an overall deprivation rank, which is used to split datazones into Deprivation Quintiles (Quintile 1 being the most deprived, and Quintile 5 the least). The most recent SIMD ranking was carried out in 2020. This section mainly focuses on the SIMD 2020 classifications, however the 2016 classifications are used to assess how deprivation has changed in Oban and Lorn when compared to the rest of Scotland.

Of the 2020 population in Oban and Lorn, **2.8%** live in the most deprived SIMD Quintile, and **0%** live in the least deprived SIMD Quintile. The following table details the percent of the population living in the 2016 SIMD Quintiles, the percent living in the 2020 SIMD Quintiles, and their difference for comparison.

Table 1: Percentage population living in the 2016 and 2020 SIMD Datazone Quintiles

Quintile	Percent of Pop (2016)	Percent of Pop (2020)	Difference
SIMD 1	3.0%	2.8%	-0.2%
SIMD 2	18.8%	17.8%	-1.0%
SIMD 3	43.7%	45.1%	1.4%
SIMD 4	34.5%	34.3%	-0.2%
SIMD 5	0.0%	0.0%	0.0%

Figure 4: Proportion of the population that reside in each 2020 SIMD quintile by domain.



Source: Scottish Government, Public Health Scotland, National Records Scotland

Households

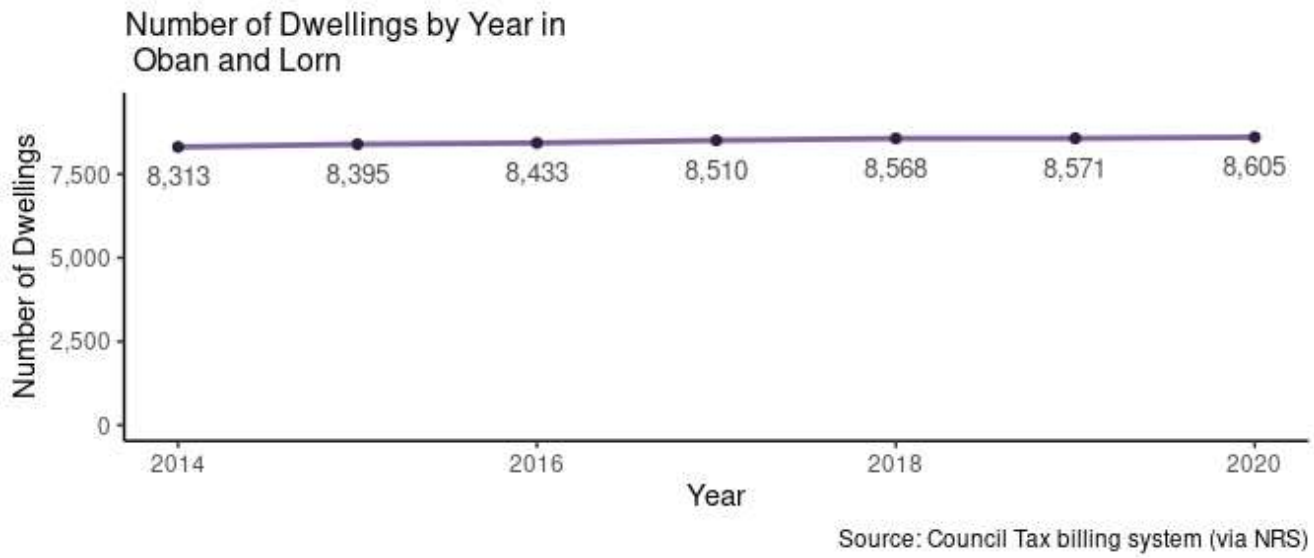
Summary:

For the most recent time periods available, Oban and Lorn Locality had:

- **8,605** dwellings, of which: **91%** were occupied and **5.4%** were second homes.
- **33%** of dwellers received a single occupant council tax discount, and **1.8%** were exempt from council tax entirely.
- **50%** of houses were within council tax bands A to C, and **18%** were in bands F to H.

The graph below shows the number of dwellings in Oban and Lorn from 2014 to 2020.

Figure 5: Number of dwellings time trend.



Of the total number of dwellings in 2020, 33% (2,818 households) were occupied by an individual receiving a single occupant council tax discount. Furthermore, 1.8% (152 households) were occupied and exempt from council tax.

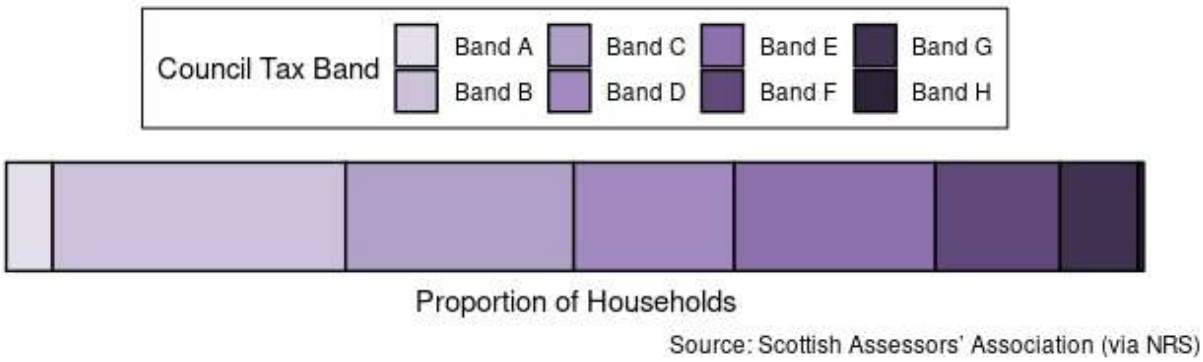
There were 461 dwellings classed as a second home in 2020, these dwellings made up 5.4% of the households in Oban and Lorn.

Table 2: Breakdown of dwelling types by year for Oban and Lorn locality.

Year	Total Dwellings	Occupied Dwellings	Vacant Dwellings	Single Occupant Tax Discount	Council Tax Exempt Dwellings	Second Homes
2014	8,313	7,512	285	2,655	153	516
2015	8,395	7,596	279	2,629	147	520
2016	8,433	7,656	278	2,675	156	499
2017	8,510	7,799	237	2,707	147	474
2018	8,568	7,809	276	2,724	154	483
2019	8,571	7,803	305	2,714	166	463
2020	8,605	7,846	298	2,818	152	461

The proportion of households within each council tax band are displayed in the chart below, figures are shown in Table 3.

Figure 6: Breakdown of households by council tax band for Oban and Lorn in 2020.



Source: Scottish Assessors' Association (via NRS)

Table 3: Percentage of households by council tax band for Oban and Lorn in 2020.

Tax Band	A	B	C	D	E	F	G	H
Percent of households	4.1%	26%	20%	14%	18%	11%	6.9%	0.49%

General Health

Summary:

For the most recent time periods available[3], Oban and Lorn Locality had:

- **An average life expectancy of 77.4 years for males and 82.2 years for females.**
- **A death rate for ages 15 to 44 of 95 deaths per 100,000 age-sex standardised population[4]**
- **24%** of the locality's population with at least one long-term physical health condition.
- A cancer registration rate of **629** registrations per 100,000 age-sex standardised population[4]
- **17.81%** of the population being prescribed medication for anxiety, depression, or psychosis.

Life Expectancy

In the latest time period available from 2016-2020 (5 year aggregate), the average life expectancy in Oban and Lorn locality was 77.4 years old for men, and 82.2 years old for women. A time trend since 2013-2017 can be seen in figure 8.

Figure 8: Average life expectancy in men and women over time.

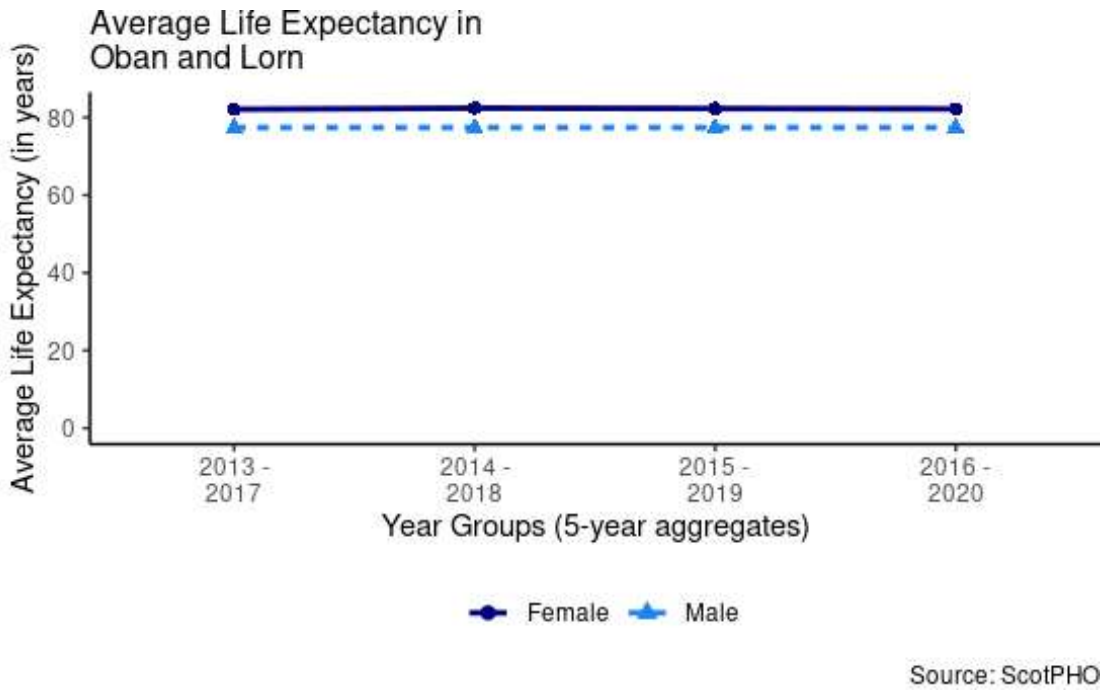


Table 5 provides the average life expectancy for men and women in different areas for the latest time period available. Please note that these are 5 year aggregates for the locality from 2016-2020, but 3 year aggregates from 2018-2020 at partnership, Health Board, and Scotland level.

Table 5: Average life expectancy in years for the latest time periods (2016-2020 aggregated years for the locality; 2018-2020 aggregated years for other areas).

	Locality	Partnership	Health Board	Scotland
	82.2	81.6	81.8	81
	77.4	78	77.6	76.8

Where Locality = Oban and Lorn, Partnership = Argyll and Bute HSCP, Health Board = NHS Highland.

Deaths, aged 15-44

The following chart shows a trend of death rates among 15-44 year olds per 100,000 age-sex standardised population[4] by area (i.e. Early mortality rate per 100,000). In the most recent aggregate time period available (from 2018-2020), the mortality rate in Oban and Lorn locality was **95** deaths per 100,000 population. Figure 10 then provides comparisons of deaths for all localities in Argyll and Bute HSCP, for the two latest time aggregates available.

Figure 9: Deaths aged 15-44 years by geographical area and over time.

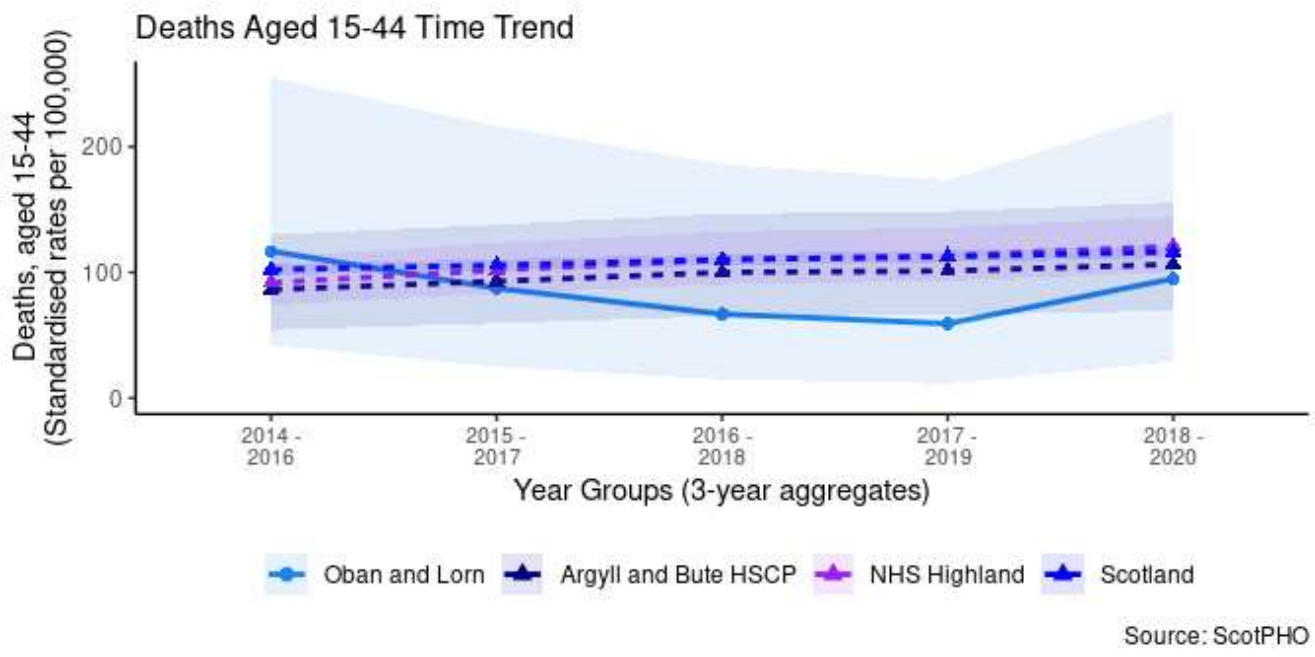
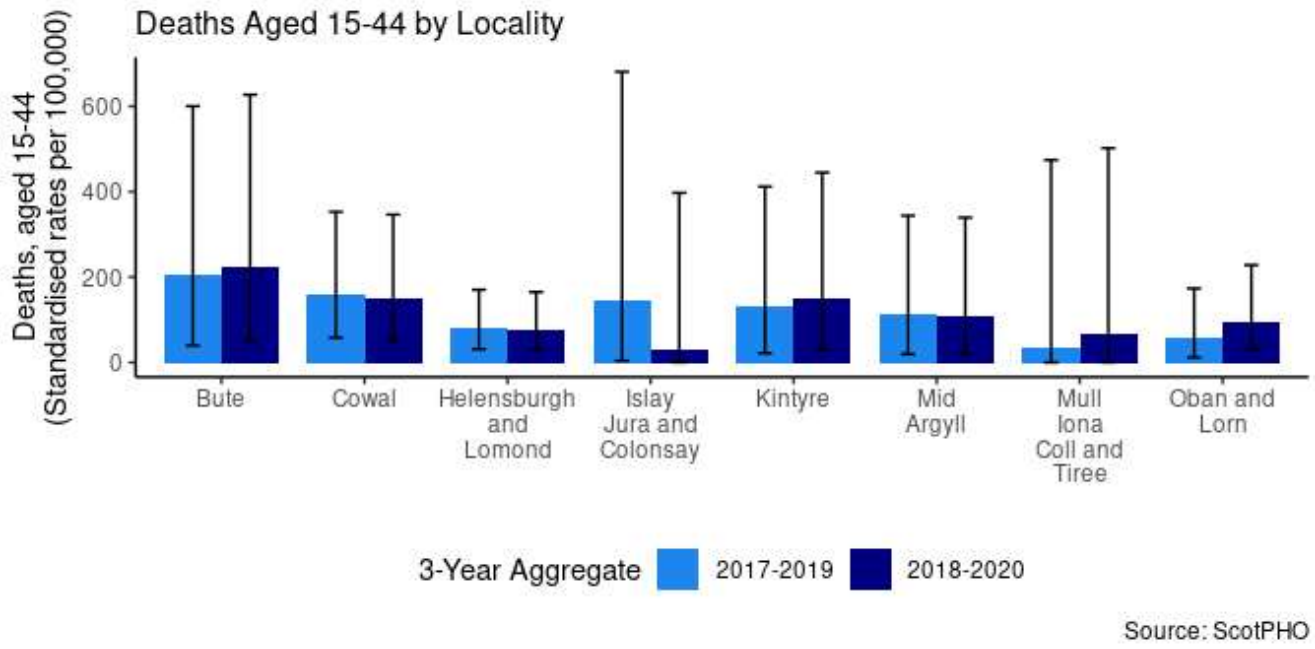
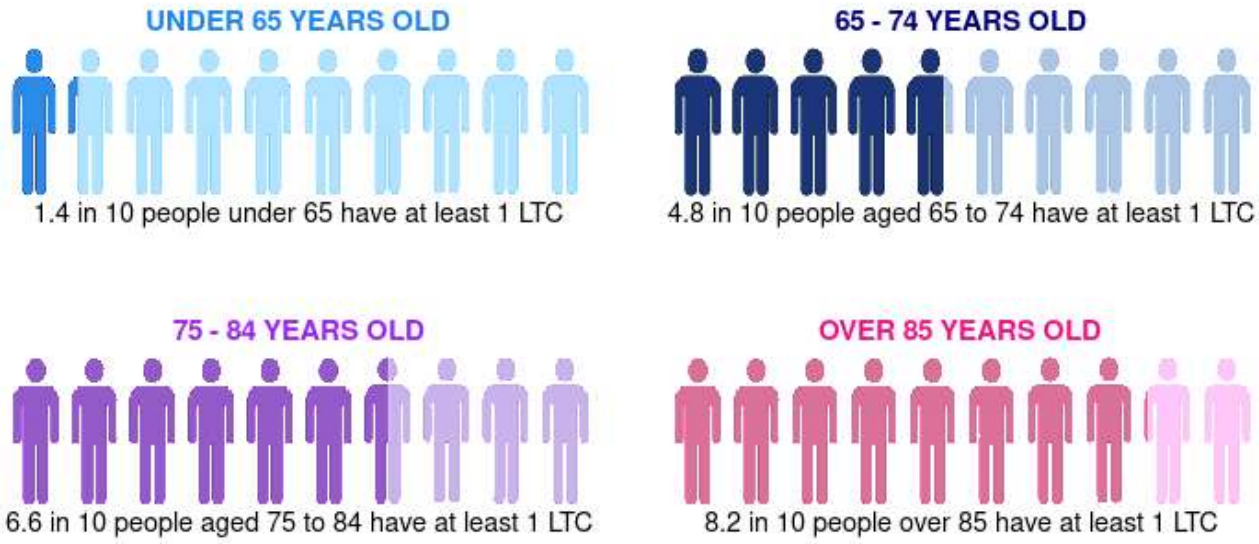


Figure 10: Deaths at ages 15-44 in Argyll and Bute HSCP localities.



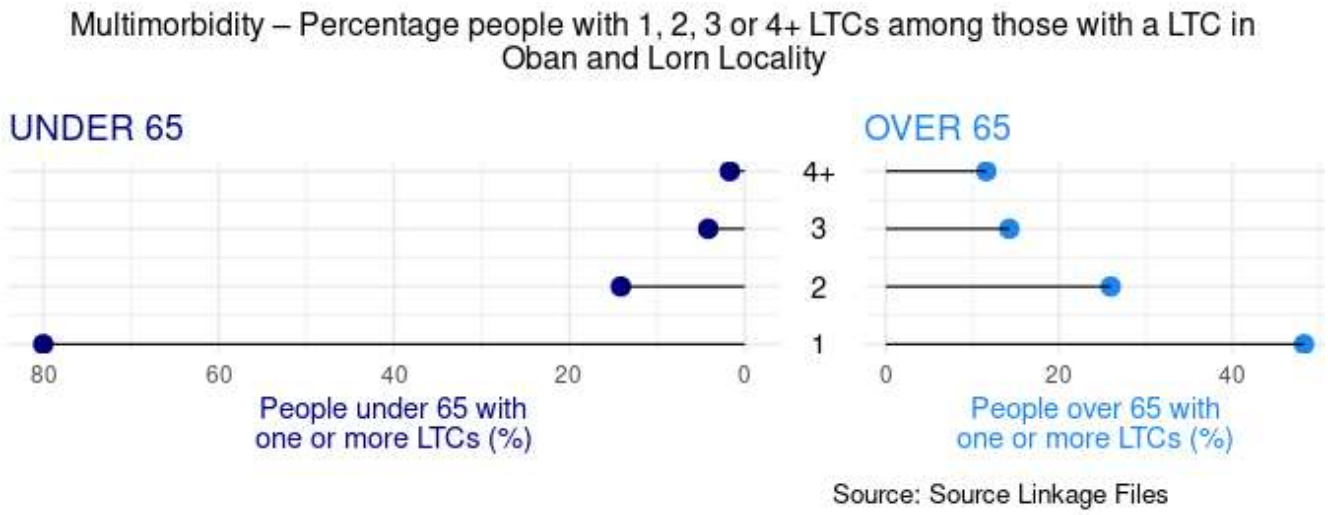
Long-Term Physical Health Conditions and Multimorbidity

In the financial year 2020/21, in Oban and Lorn Locality, **24%** of the total population had at least one physical long-term condition (LTC). These include: cardiovascular, neurodegenerative, and respiratory conditions, as well as other organ conditions (namely liver disease and renal failure), arthritis, cancer, diabetes, and epilepsy. *Please see footnotes for information and caveats on identifying LTCs.*[5]



The co-occurrence of two or more conditions, known as multimorbidity, is broken down in figure 11, distinguishing between age groups. Note that this chart *excludes* the population in the locality who do not have any physical long-term conditions. Figure 13 therefore shows that among the people who have a LTC, **20**% of those under the age of 65 have more than one, compared to **52**% of those aged over 65.

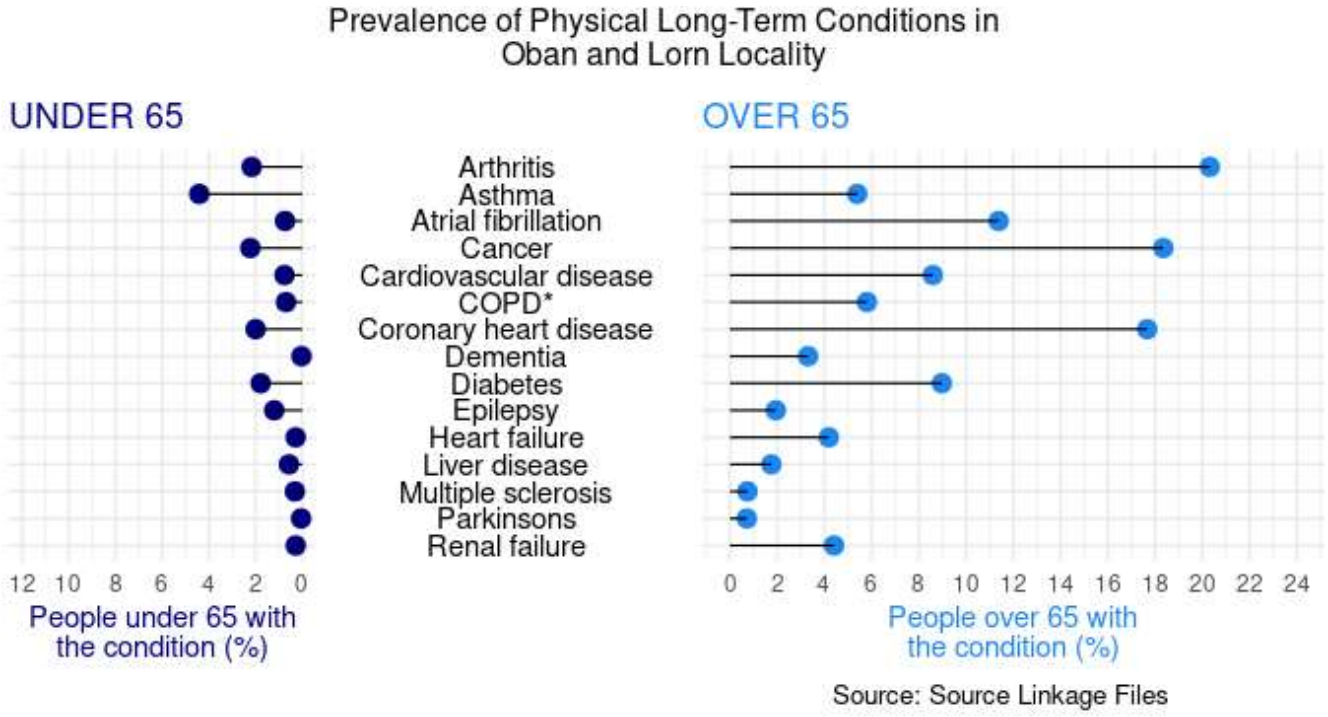
Figure 11: Multimorbidity of physical long-term conditions by age group in 2020/21.



Most common physical Long-Term Conditions (LTCs)

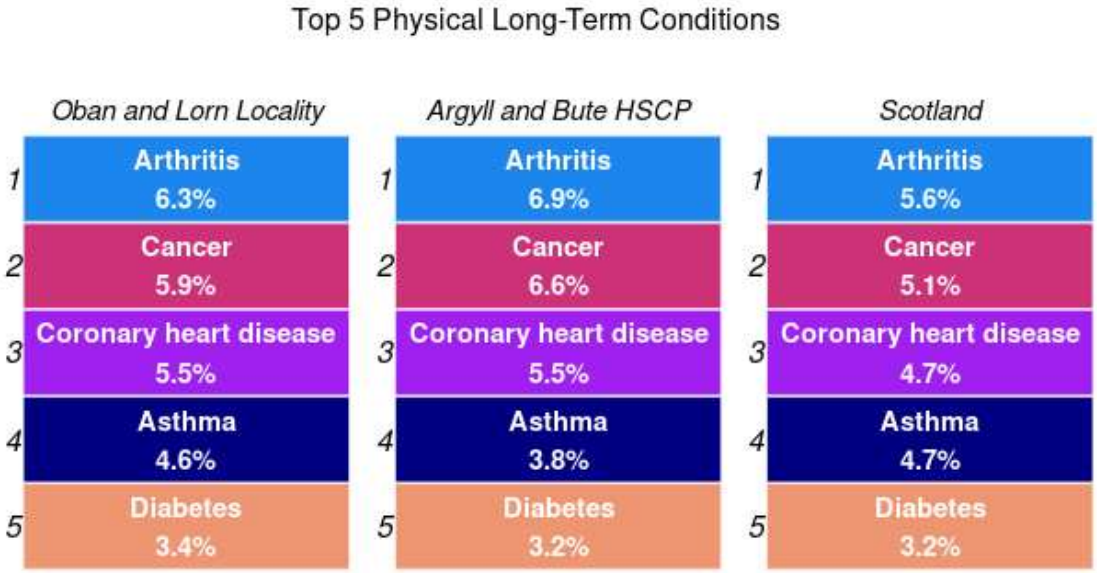
Below is a breakdown of the physical LTCs, for the financial year 2020/21. Figure 12 shows the prevalence of different LTCs in each age group in Oban and Lorn locality, and Table 6 illustrates the top 5 physical LTCs across all ages at locality, partnership, and Scotland level.

Figure 12: Percentage people with each physical LTC, split by age group.



**COPD: Chronic Obstructive Pulmonary Disease*

Table 6: Prevalence of the five most common physical LTCs as a percentage of the population across geographical areas (where 1 = most prevalent).



Cancer Registrations

For the period 2017-2019, there were 111 new cancer registrations per year on average (**629** registrations per 100,000 age-sex standardised population) in Oban and Lorn locality. This is a **7.5%** decrease in cancer registrations rate from the previous aggregate period 2016-2018. Figure 13 shows changes over time since 2014-2016, and Figure 14 compares the rates of localities in Argyll and Bute HSCP for the two latest available time periods.

Figure 13: Cancer registration rate over time and by geographical area.

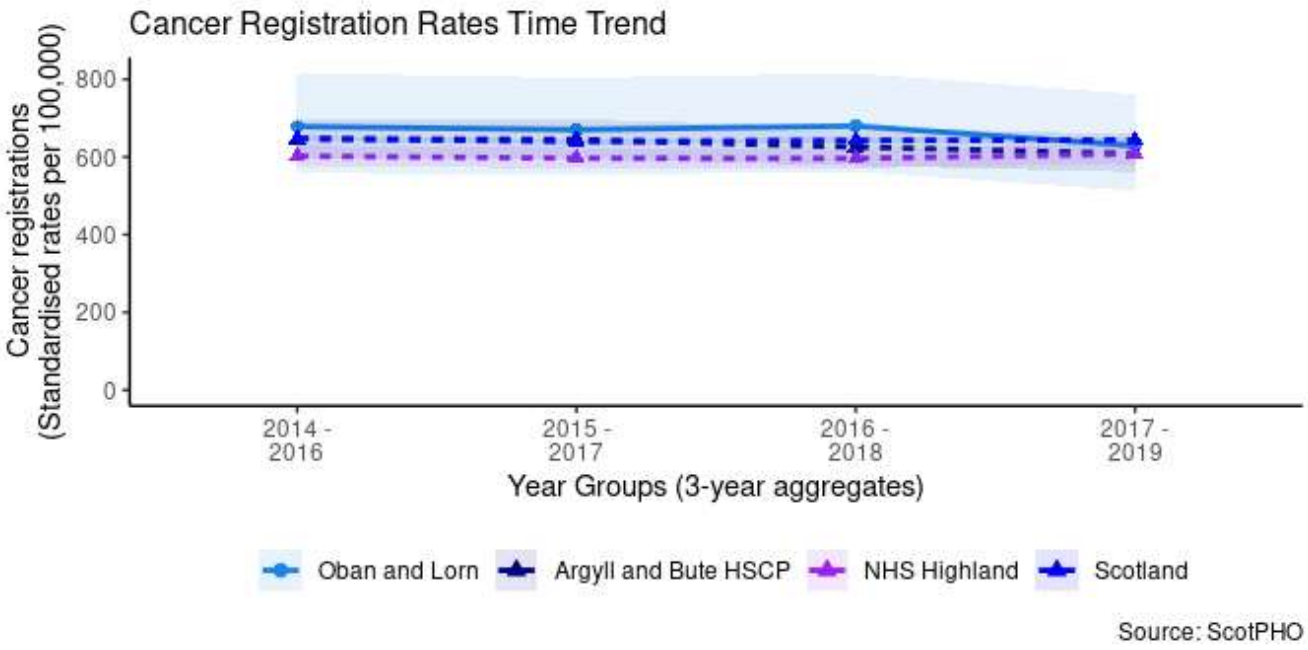
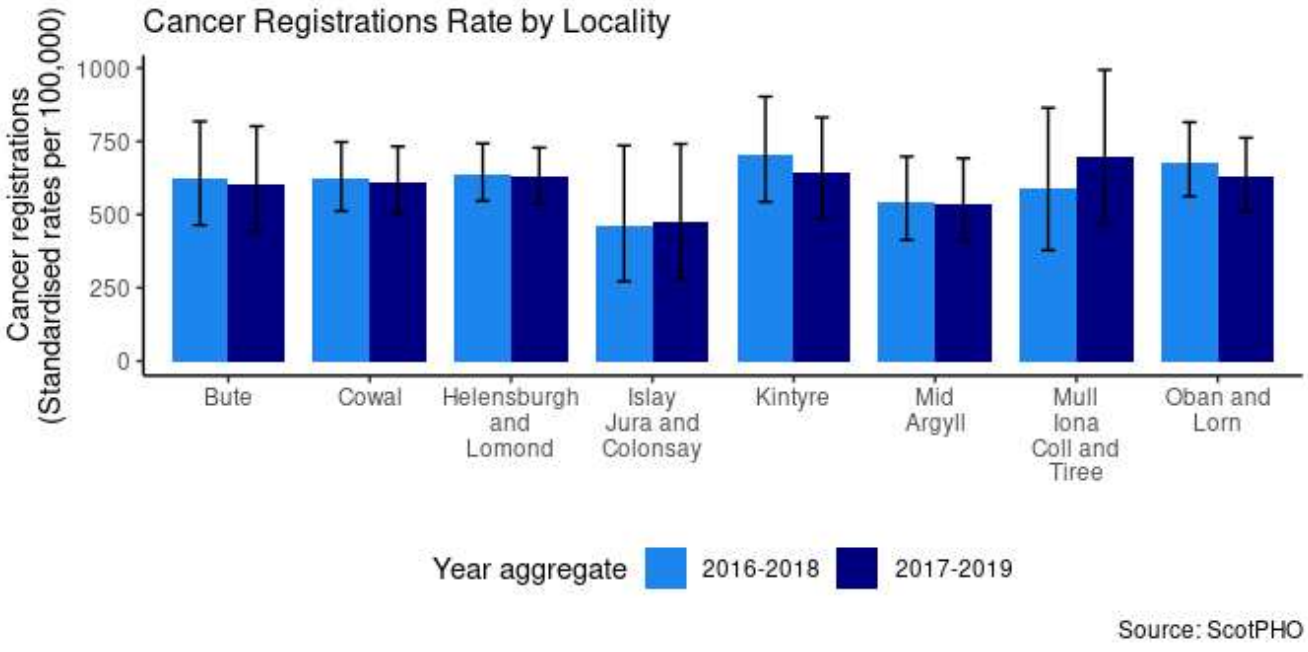


Figure 14: Cancer registration rates in Argyll and Bute HSCP localities.



Anxiety, Depression, and Psychosis Prescriptions

In the 2019/20 financial year, 17.81% of people were prescribed medication for anxiety, depression, or psychosis (ADP) in Oban and Lorn Locality. This is a 4.6% increase from the previous financial year. Differences over time and between areas may relate to multiple factors, only one of which is underlying disease. Note that data are based on main original licensed use for the prescriptions and some drugs included may be prescribed for other purposes.

Figure 15: Percentage population prescribed ADP medication in Argyll and Bute HSCP localities.

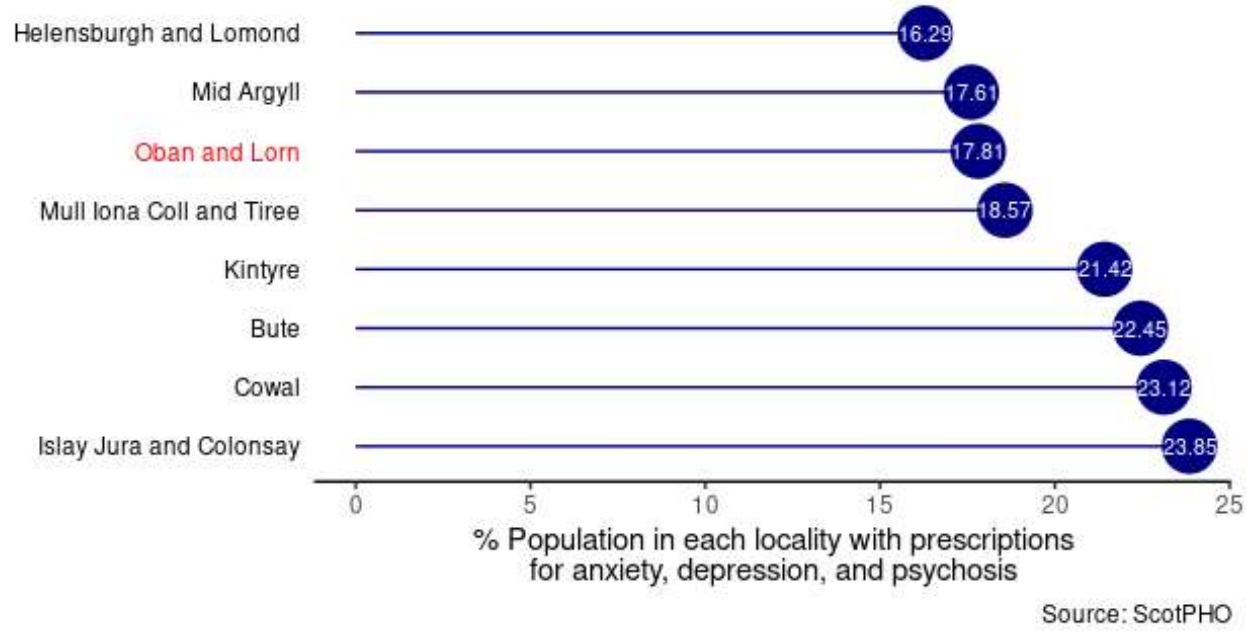
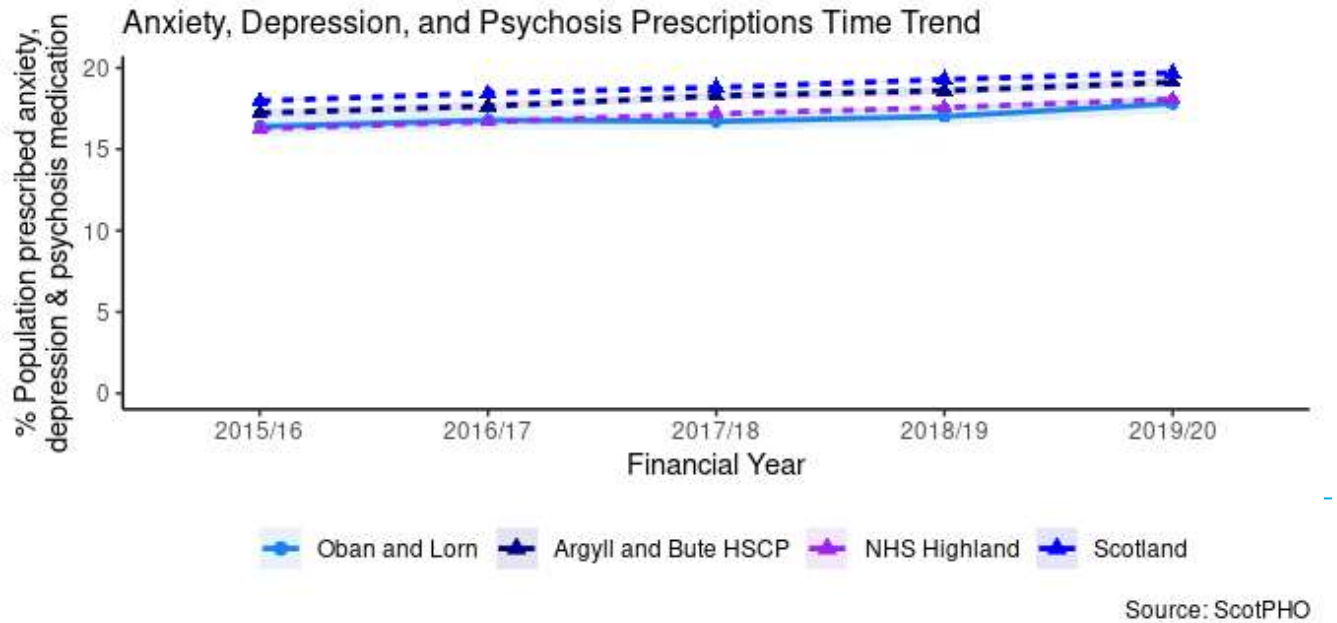


Figure 16: ADP prescriptions over time and by geographical area.



Behavioural Factors

Summary:

Mental and physical wellbeing has close ties with people's behaviours. Life circumstances including financial security, employment and location are interlinked with behavioural factors. This section provides data on drug-related hospital admissions, alcohol-related hospital admissions, alcohol-specific mortalities and bowel screening uptake, to give an overview of some behaviours known to be associated with health and wellbeing outcomes.

For the most recent time periods available[3], Oban and Lorn had:

- **187** drug-related hospital admissions per 100,000 age-sex standardised population[4]. This is a lower rate of admissions than for Scotland (221).
- **800** alcohol-related hospital admissions per 100,000 age-sex standardised population[4].
- **19** alcohol-specific mortalities per 100,000 age-sex standardised population[4].
- a **63%** uptake of bowel cancer screening for the eligible population.

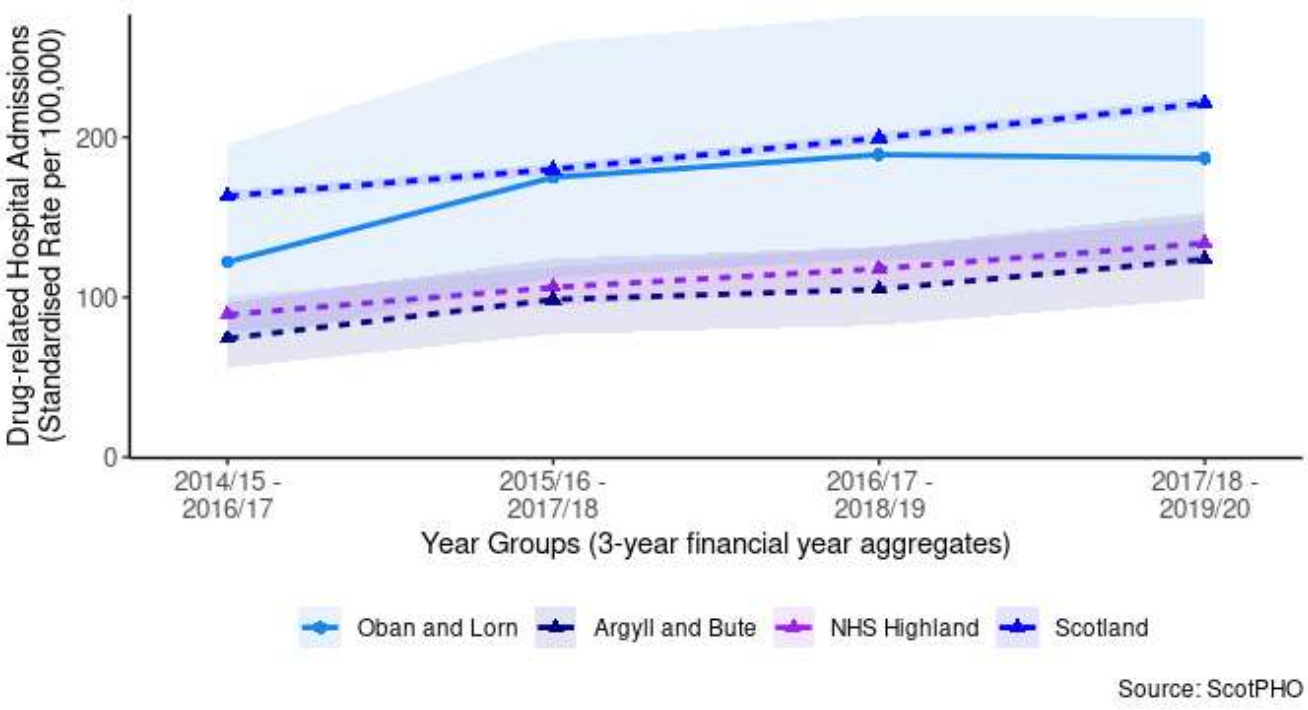
Drug-related Hospital Admissions

There were 187 drug-related hospital admissions per 100,000 age-sex standardised population[4] in Oban and Lorn locality for the most recent time period available (3 year financial year aggregate for 2017/18 - 2019/20).

This is a 53% increase since 2014/15 - 2016/17 (3 financial year aggregates).

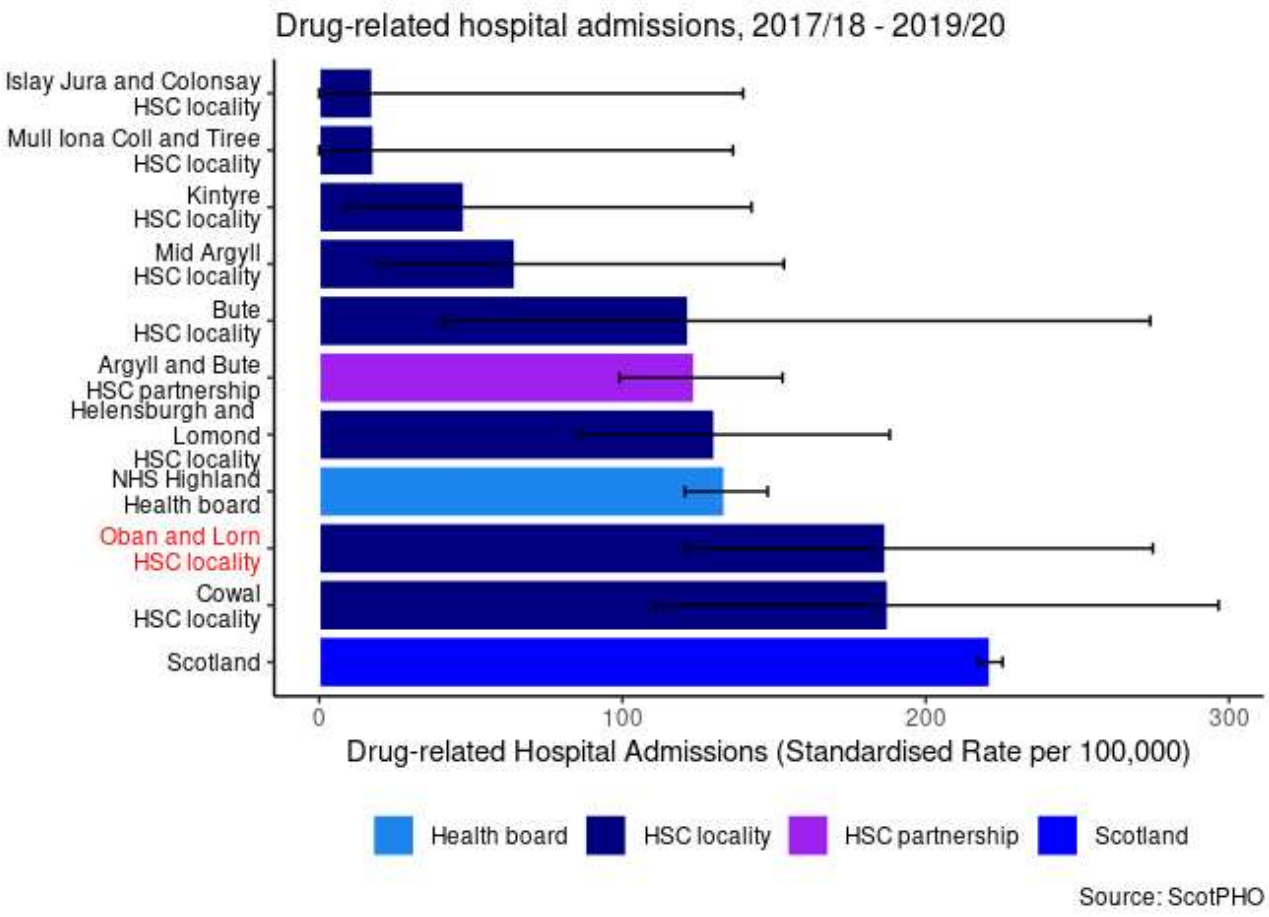
A trend of the change in drug-related hospital admissions for Oban and Lorn locality compared with Scotland, Argyll and Bute HSCP and NHS Highland is shown in the chart below from 2014/15 - 2016/17 onwards.

Figure 17: Trend of Drug-related Hospital Admission Rates by geographical area.



A comparison of areas at the most recent time period (2017/18 - 2019/20 aggregated financial years) is available below. This shows Oban and Lorn locality has a higher rate of admissions (187) than Argyll and Bute Partnership (124), and a lower rate of admissions than Scotland (221) overall.

Figure 18: Comparison of Drug-related Hospital Admission Rates for the period 2017/18 - 2019/20.

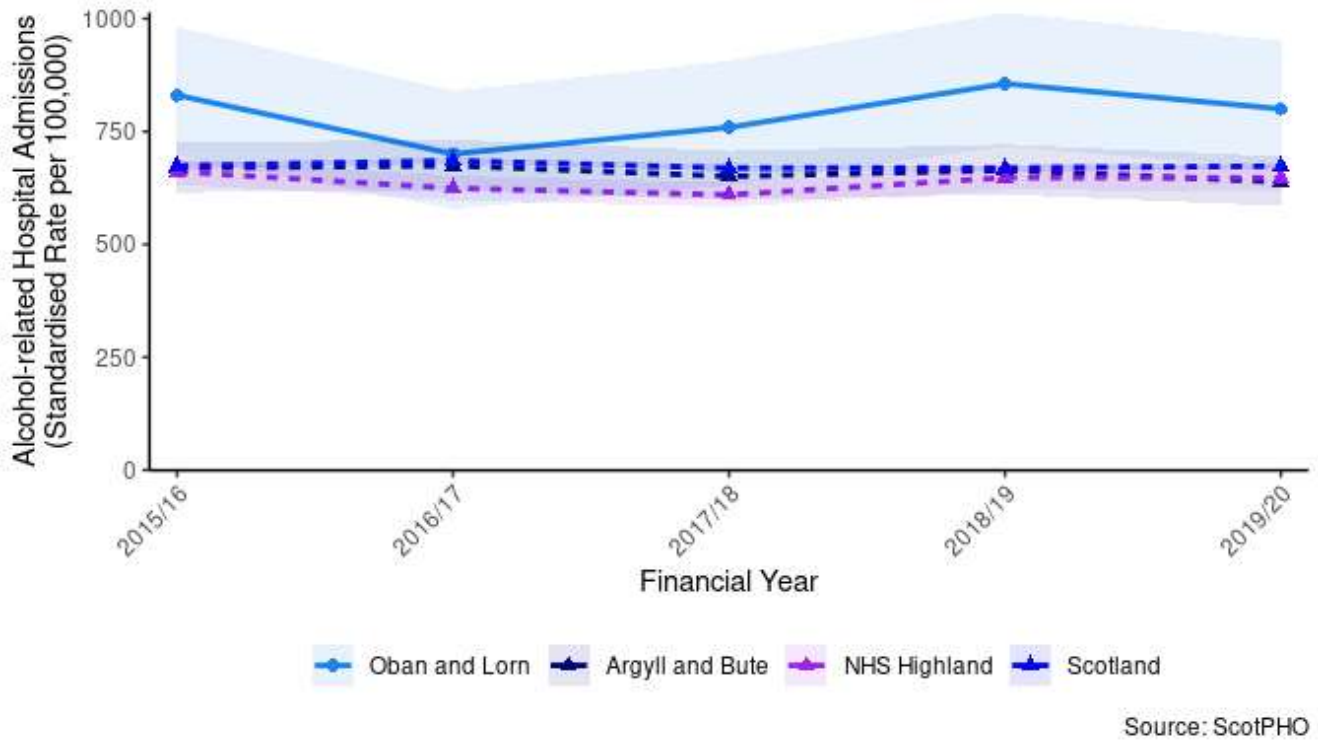


Alcohol-related Hospital Admissions

The 2019/20 alcohol-related admissions rate is 800 per 100,000 age-sex standardised population[4], which is a 3.6% decrease overall since 2015/16.

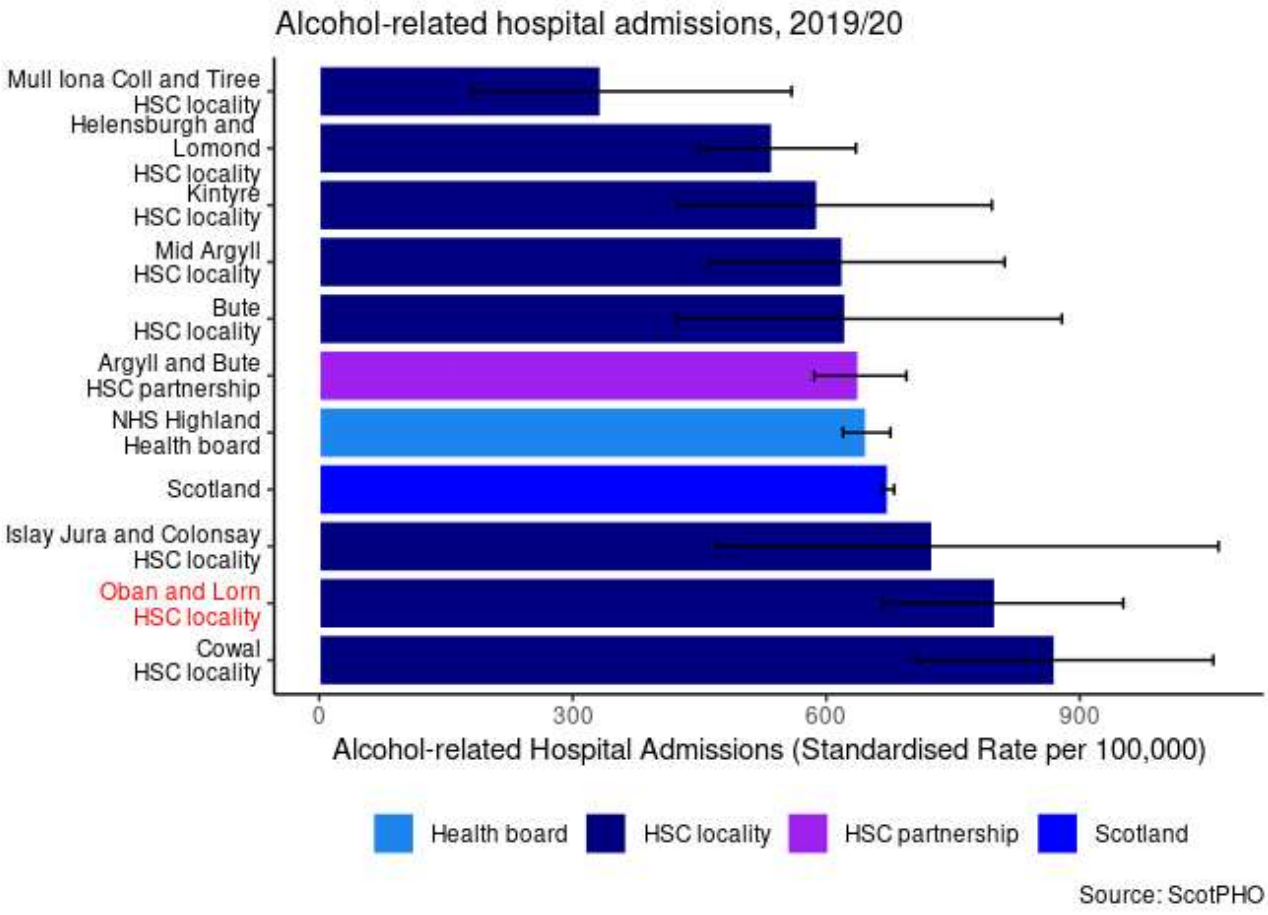
The chart below shows a trend of alcohol-related hospital admissions for Oban and Lorn locality compared with Scotland, Argyll and Bute Partnership and NHS Highland from financial year 2015/16 to 2019/20.

Figure 19: Trend of Alcohol-related Hospital Admission Rates by geographical area.



Comparison across different areas for 2019/20 is shown in Figure 20. This shows that Oban and Lorn locality had a higher alcohol-related hospital admissions rate (800) compared to Scotland (673).

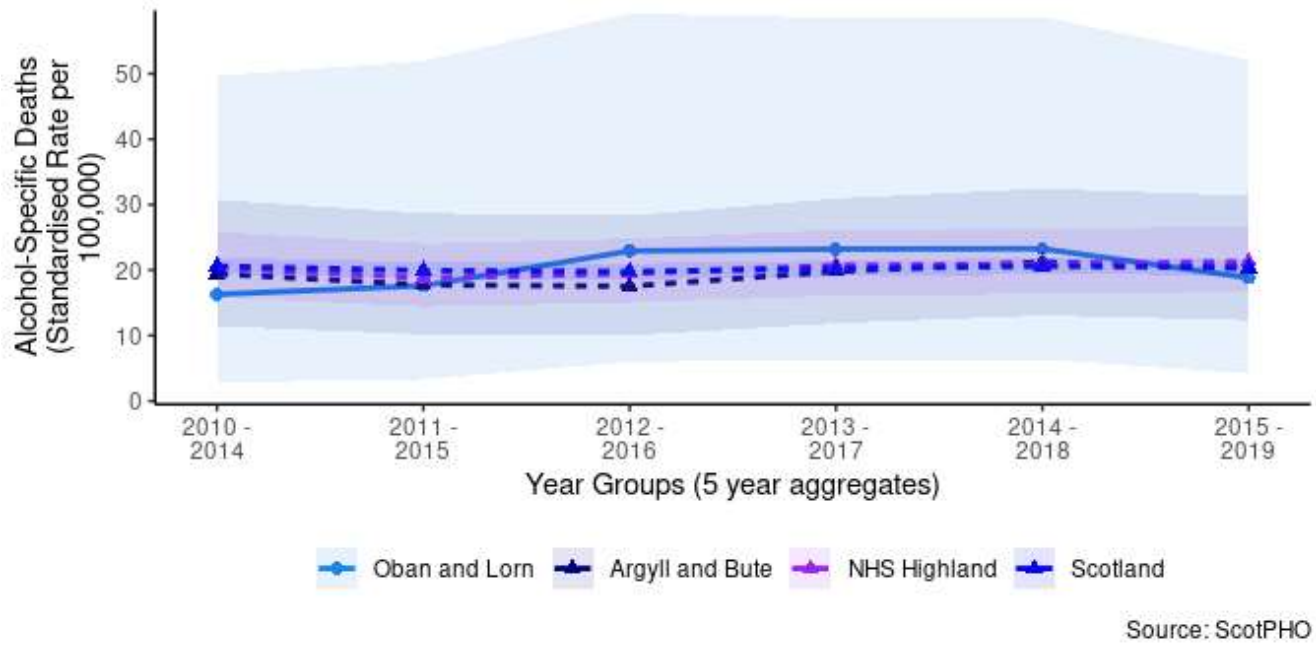
Figure 20: Comparison of Alcohol-related Hospital Admission Rates for 2019/20.



Alcohol-Specific Deaths

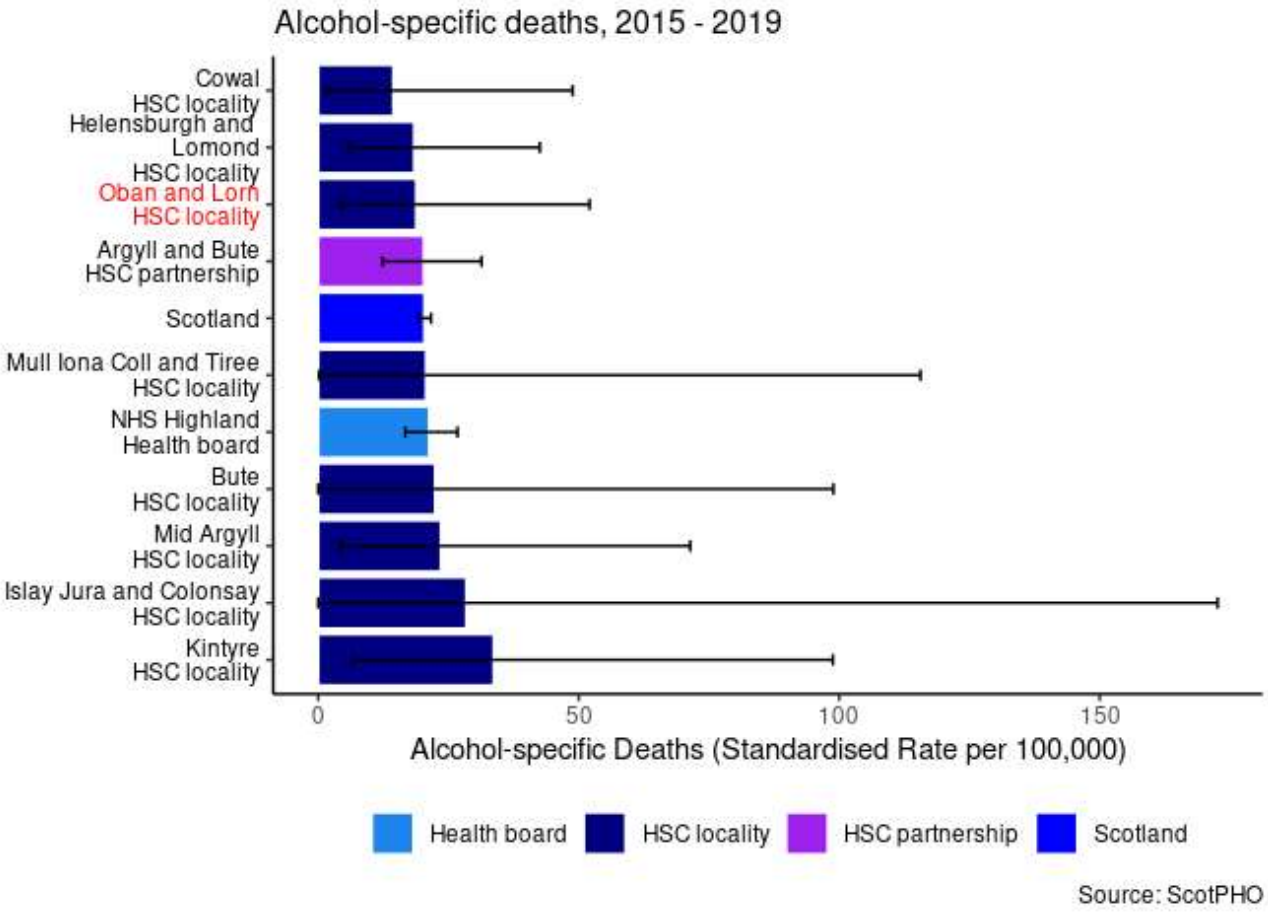
Data on alcohol-specific deaths is available as 5 year aggregates. The rate of alcohol-specific deaths is currently higher in Oban and Lorn than the rate in 2010 - 2014 (15% change).

Figure 21: Trend of Alcohol-Specific Death Rates by geographical area.



A comparison across different areas illustrates that Oban and Lorn locality has a lower alcohol-specific death rate compared to Scotland as a whole.

Figure 22: Comparison of Alcohol-related Death Rates for the period 2015 - 2019 (5 year aggregate).

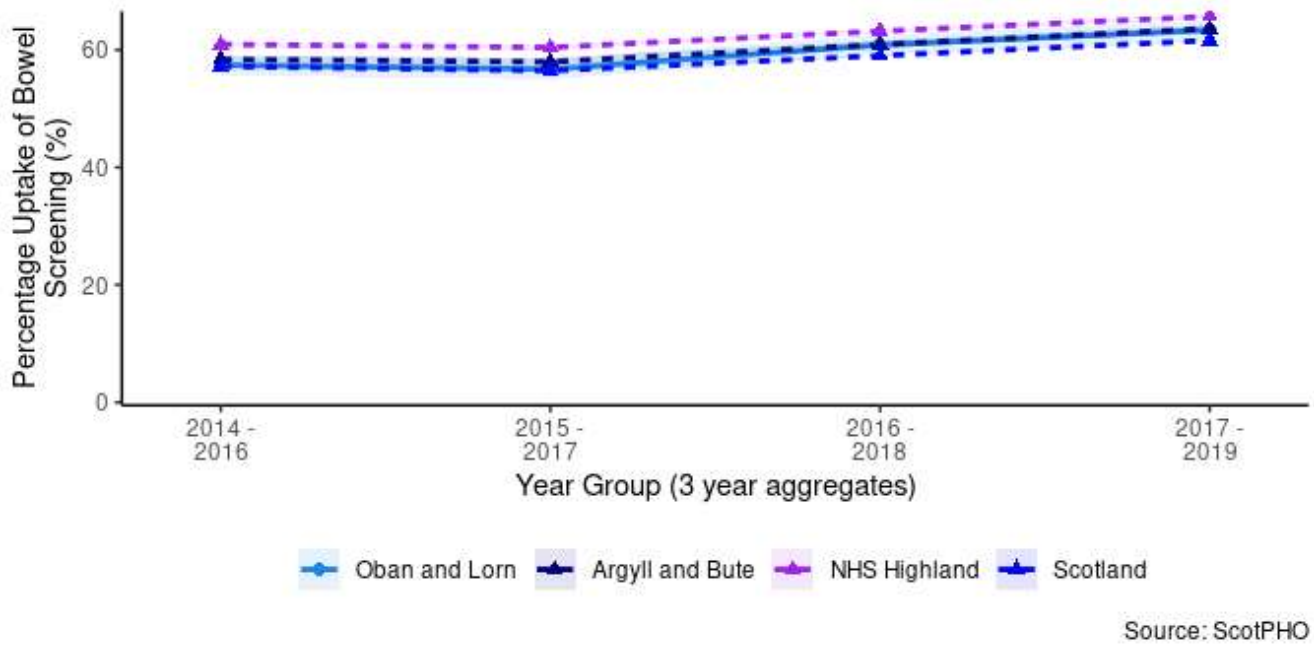


Bowel Screening Uptake

Bowel screening is offered every two years to eligible men and women aged between 50-74 years old. Eligible people are posted a test kit which is completed at home. Since 1st April 2013, those aged 75 and over can also self-refer and opt into screening.

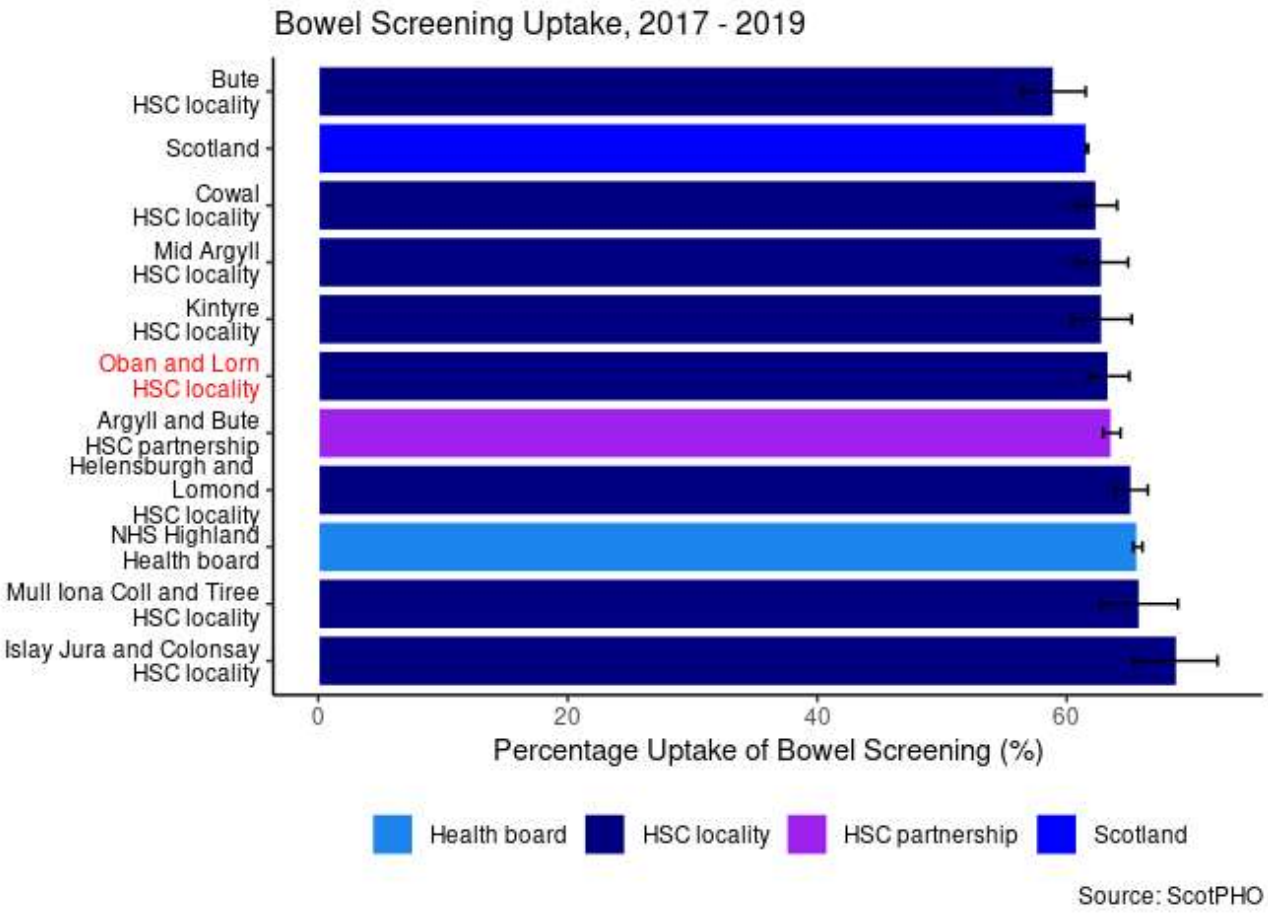
A trend of the percentage uptake of bowel screening among the eligible population is shown below for Oban and Lorn locality compared with Scotland, Argyll and Bute HSCP and NHS Highland. Data is suppressed into 3 year aggregates. The 2017 - 2019 uptake rate for Oban and Lorn is **63%**.

Figure 23: Trend of Bowel Screening Uptake for eligible men and women, by geographical area.



Compared with Scotland, Oban and Lorn locality has a higher percentage uptake of bowel cancer screening for the period 2017 - 2019.

Figure 24: Comparison of Bowel Screening Uptake for 2017 - 2019.



Hospital and Community Care

This section includes acute hospital data, delayed discharge bed days and A&E attendances. Please note that for 2020 onwards, hospital activity would have been severely affected by the COVID-19 pandemic. Information on how this has had a wider impact is provided in Footnote 6 at the end of the document.

For the most recent time periods available, Oban and Lorn had:

- **9,668** emergency hospital admissions per 100,000 population.
- **66,685** unscheduled acute specialty bed days per 100,000 population.
- **30,947** A&E attendances per 100,000 population.
- **9,921** delayed discharge bed days per 100,000 population.
- **969** emergency hospital admissions from falls per 100,000 population.
- **136** emergency readmissions (28 day) per 1,000 discharges.
- **1,441** potentially preventable hospital admissions per 100,000 population.
- People on average spent **92%** of their last 6 months of life in a community setting.

Emergency Admissions

Figure 25: Emergency admissions by age group

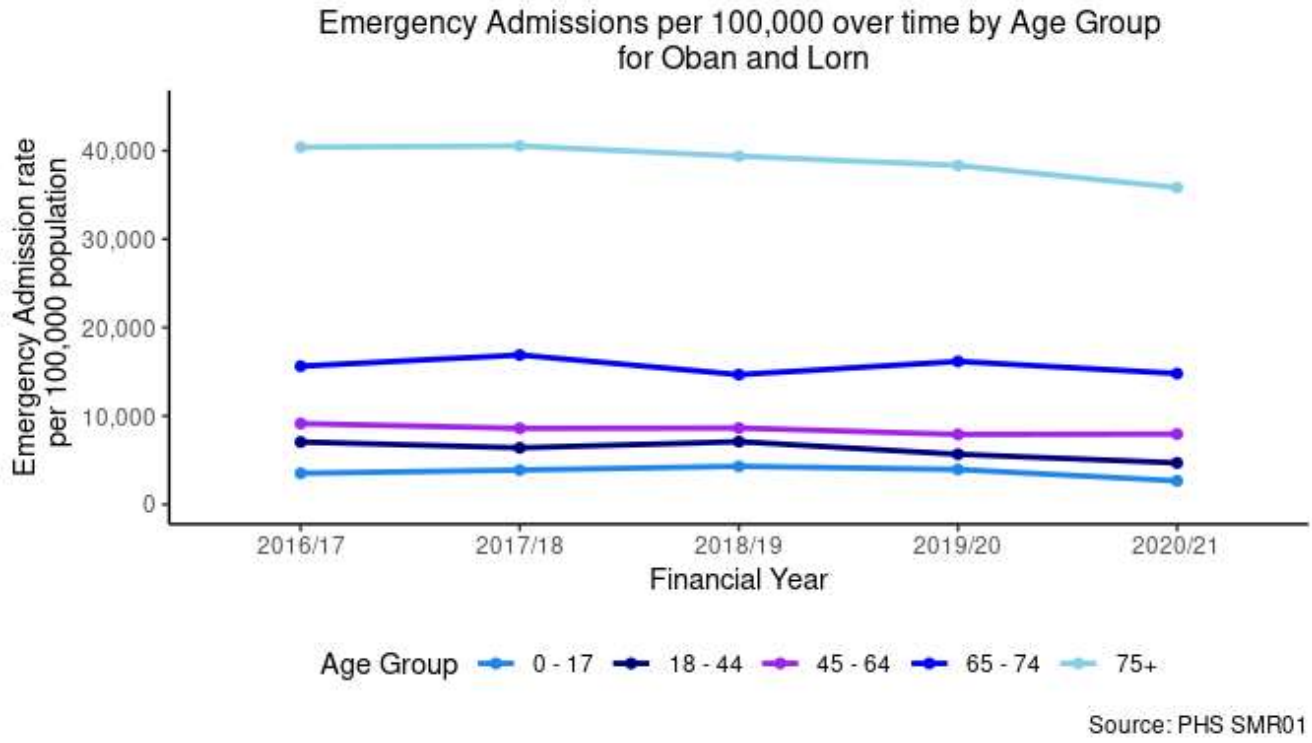
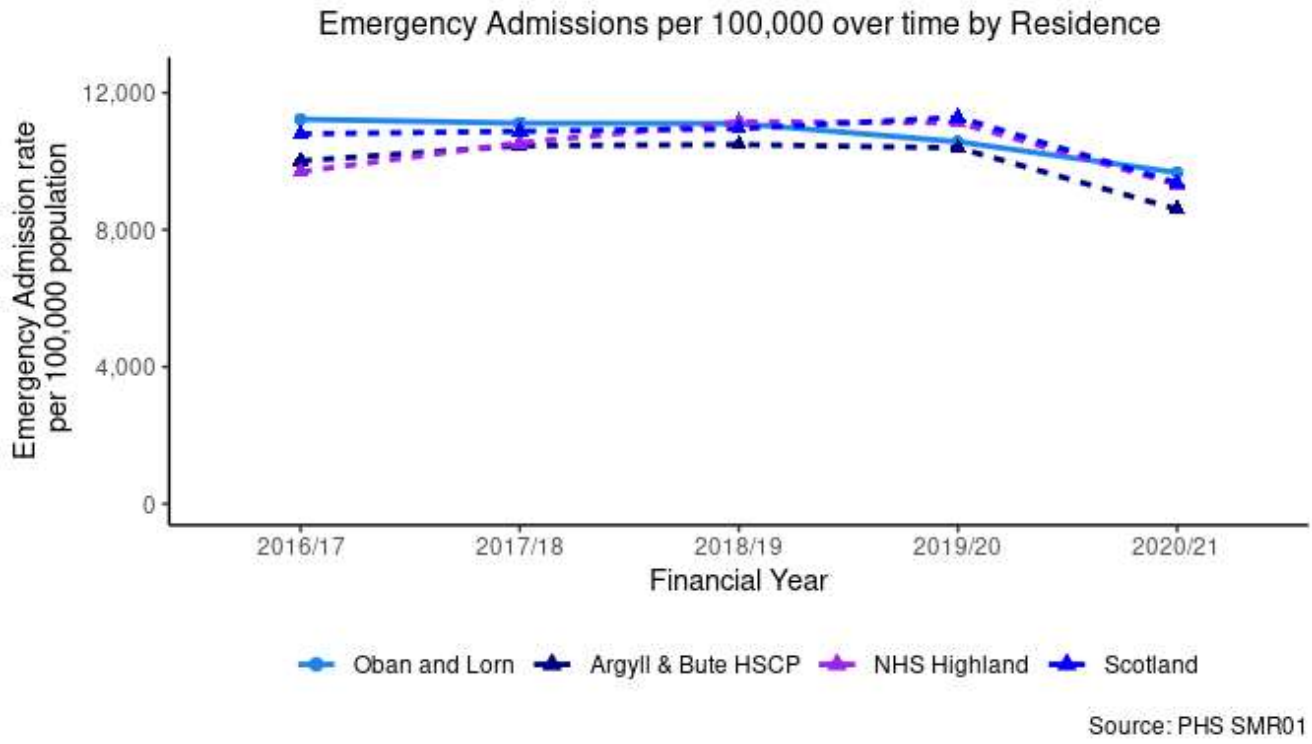


Figure 26: Emergency admissions by geographical area



Unscheduled Acute Bed Days

Figure 27: Unscheduled bed days by age group

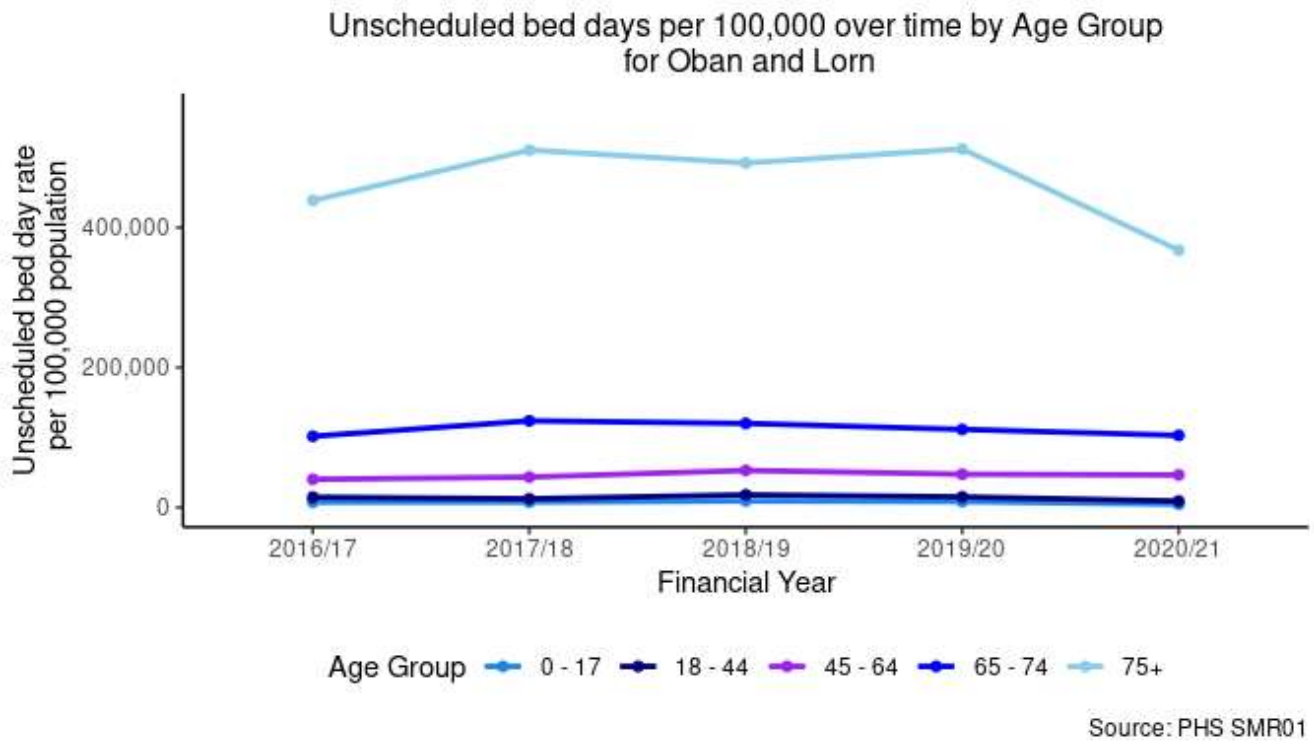
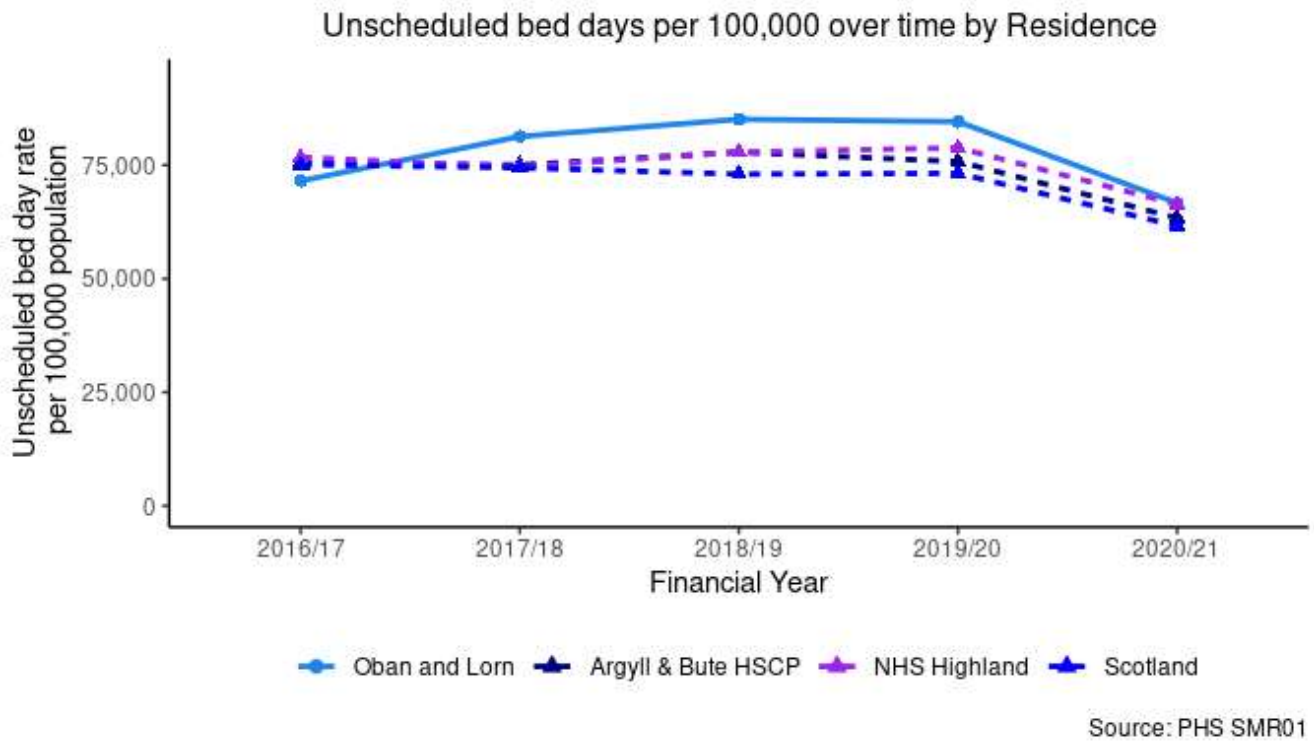
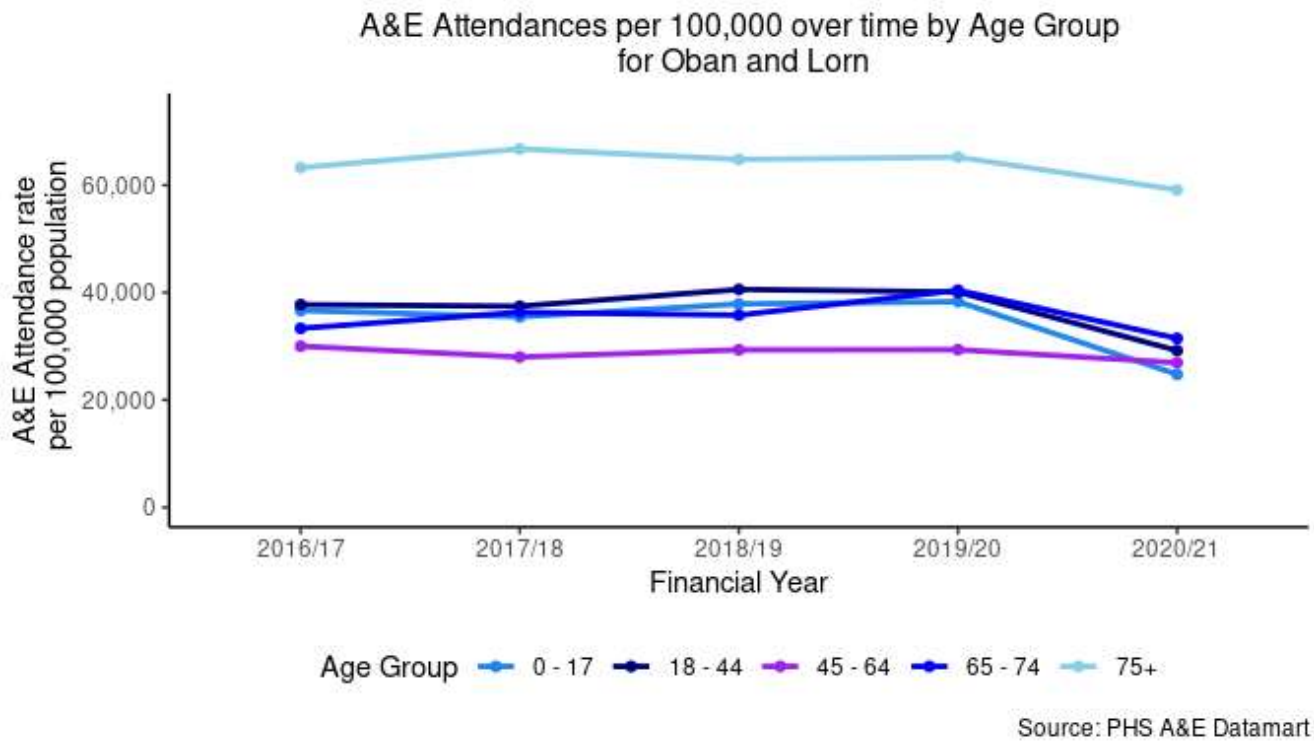


Figure 28: Unscheduled bed days by geographical area



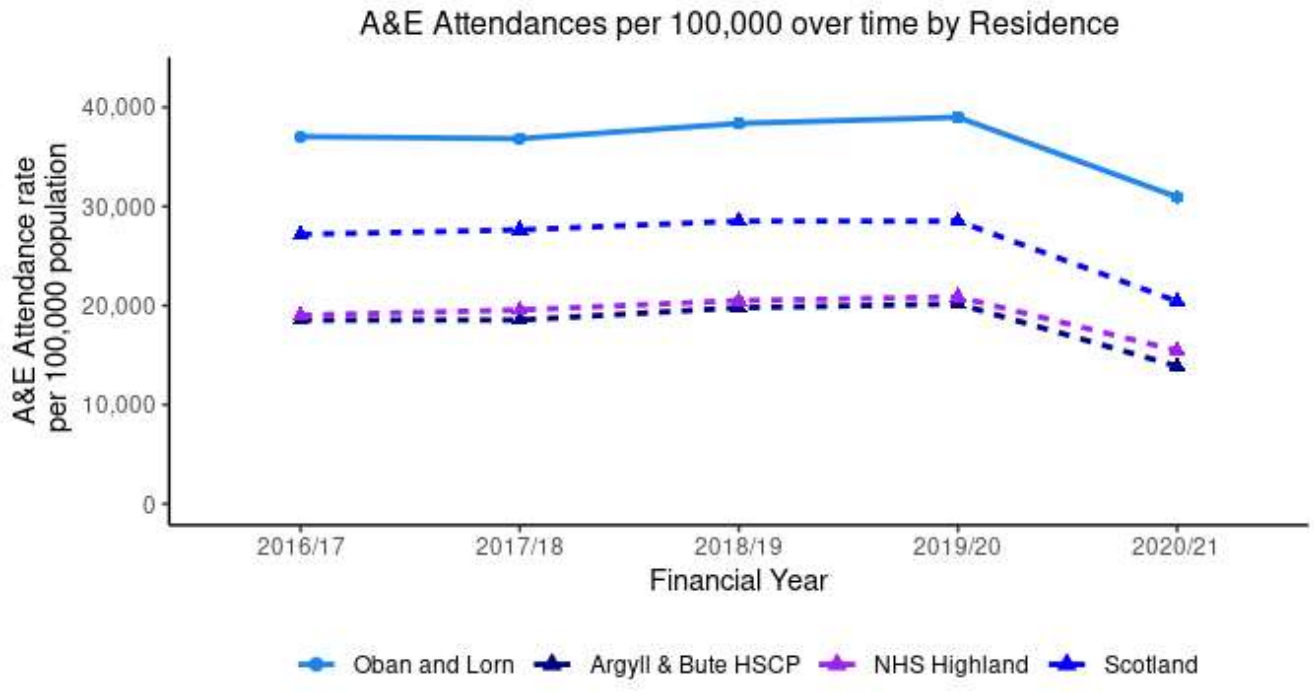
A&E Attendances

Figure 29: A&E attendances by age group



Source: PHS A&E Datamart

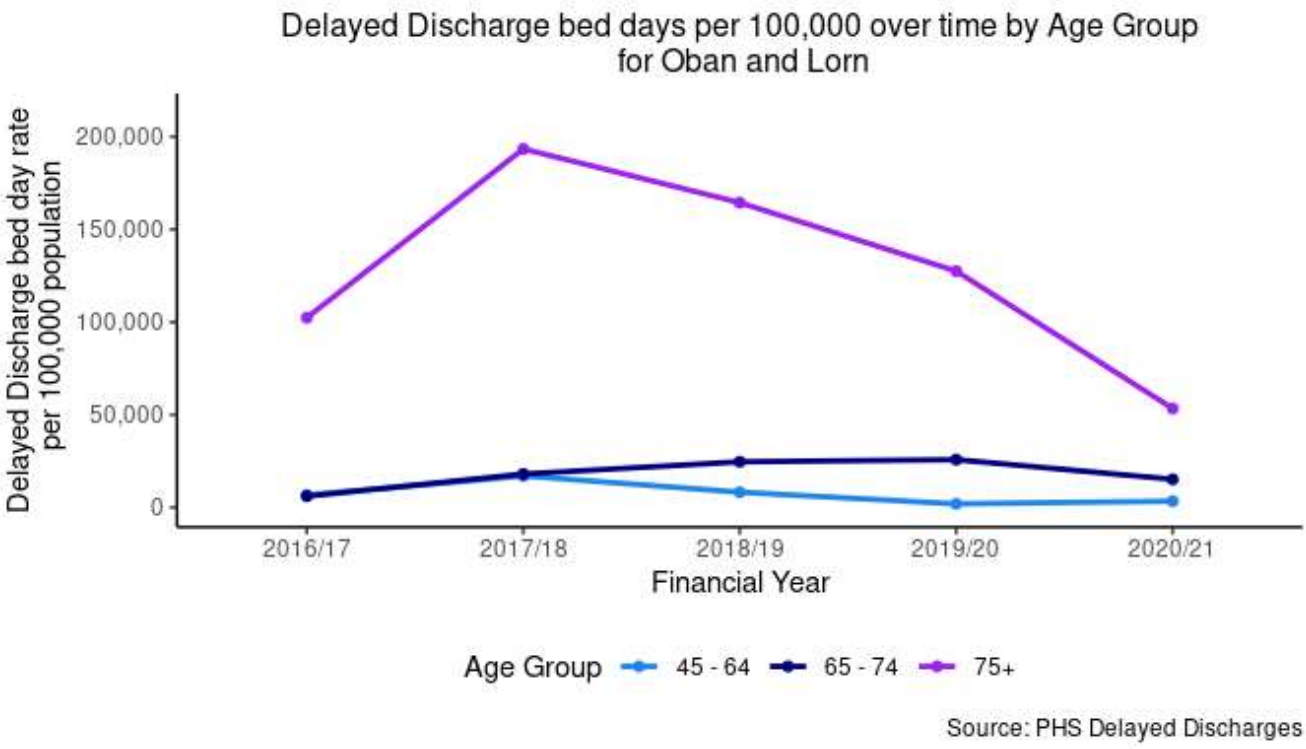
Figure 30: A&E attendances by geographical area



Source: PHS A&E Datamart

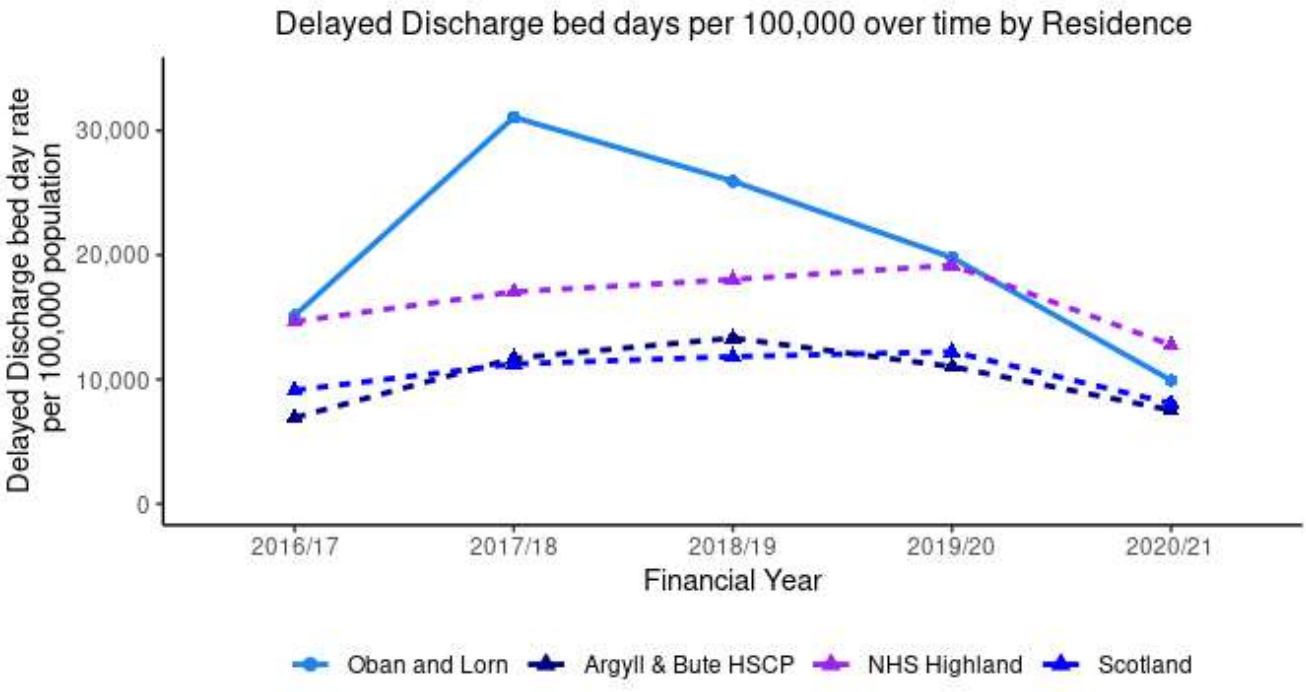
Delayed Discharge Bed Days

Figure 31: Delayed discharge bed days by age group



Source: PHS Delayed Discharges

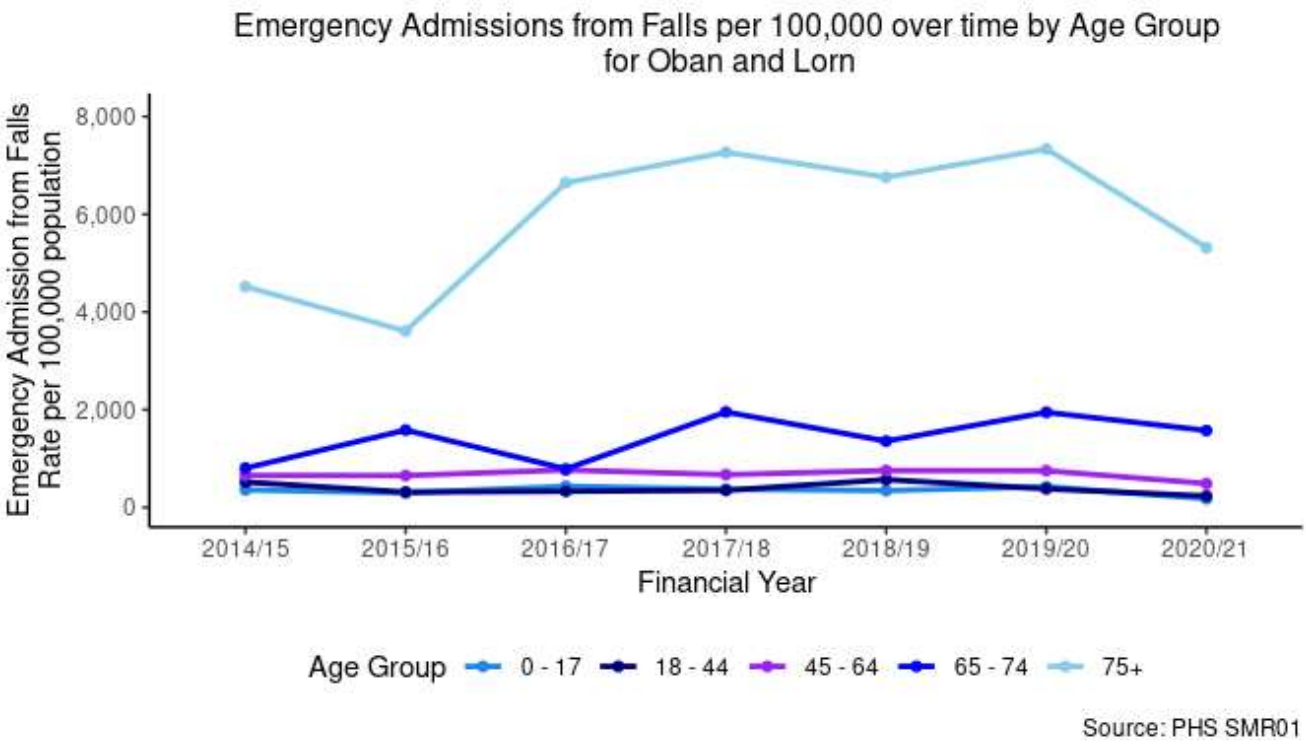
Figure 32: Delayed discharge bed days by geographical area



Source: PHS Delayed Discharges

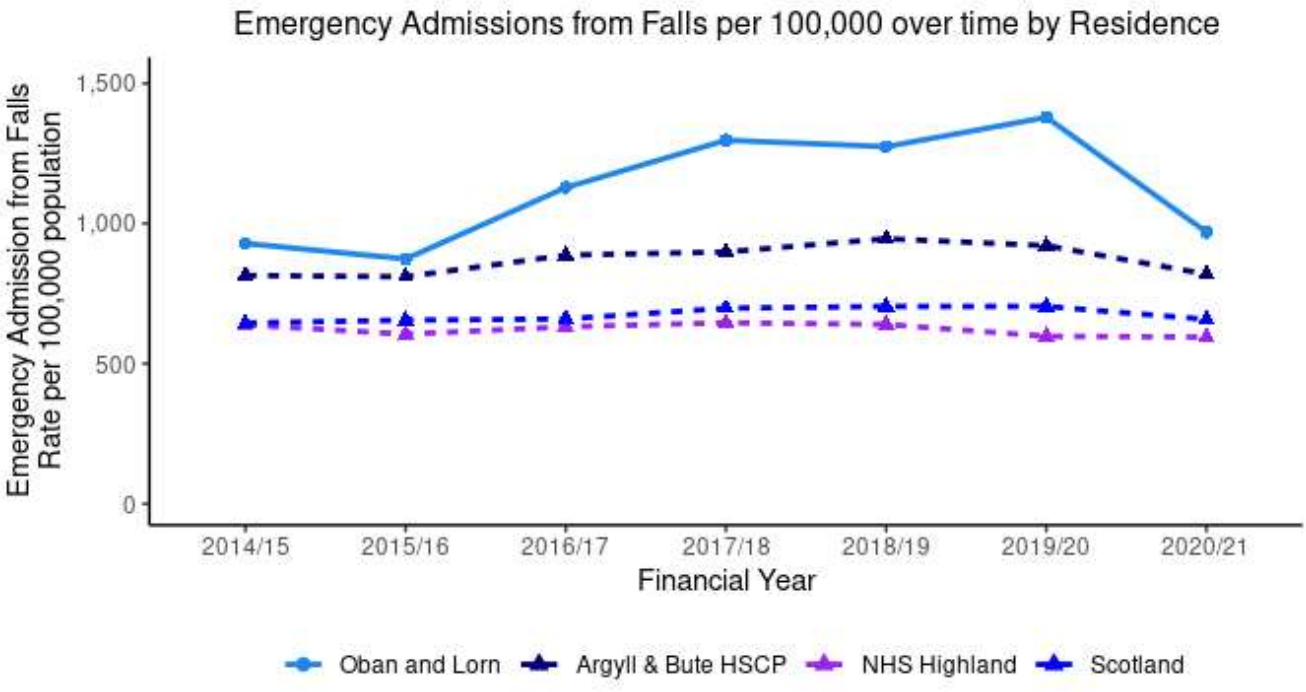
Emergency Admissions from a Fall

Figure 33: Falls by age group



Source: PHS SMR01

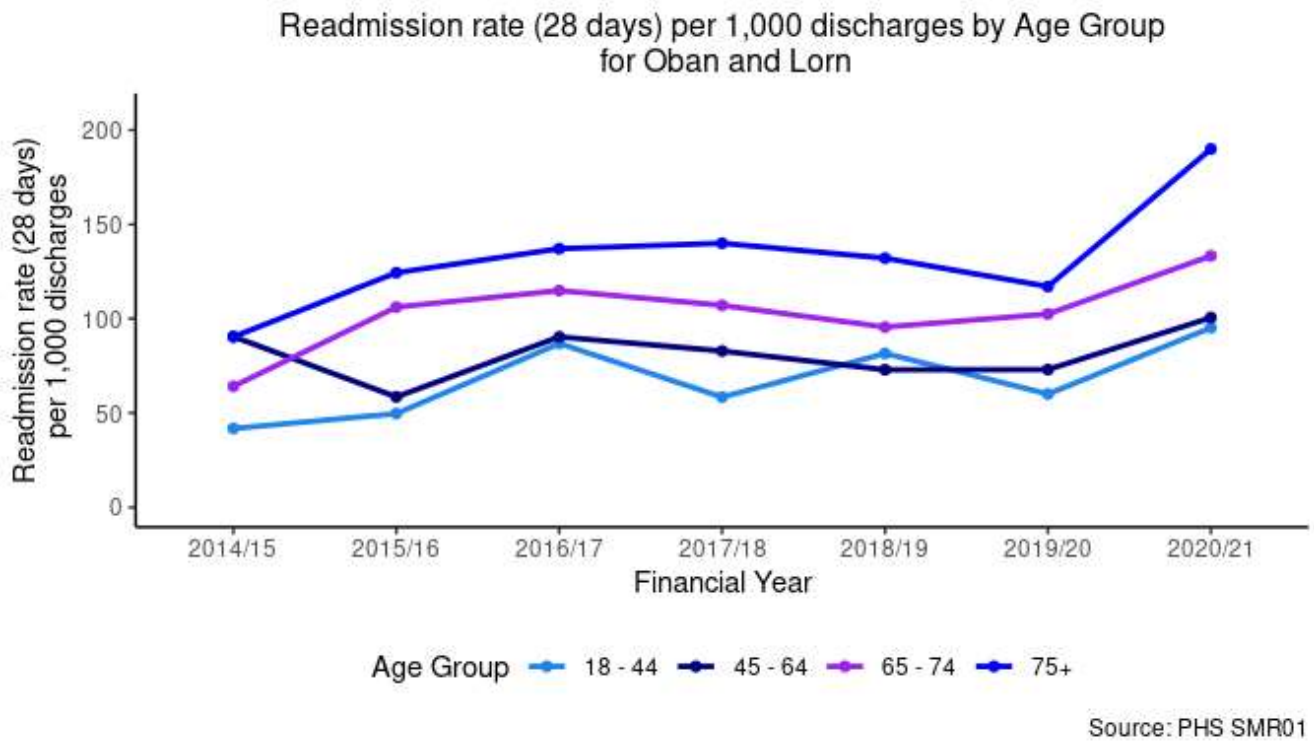
Figure 34: Falls by geographical area



Source: PHS SMR01

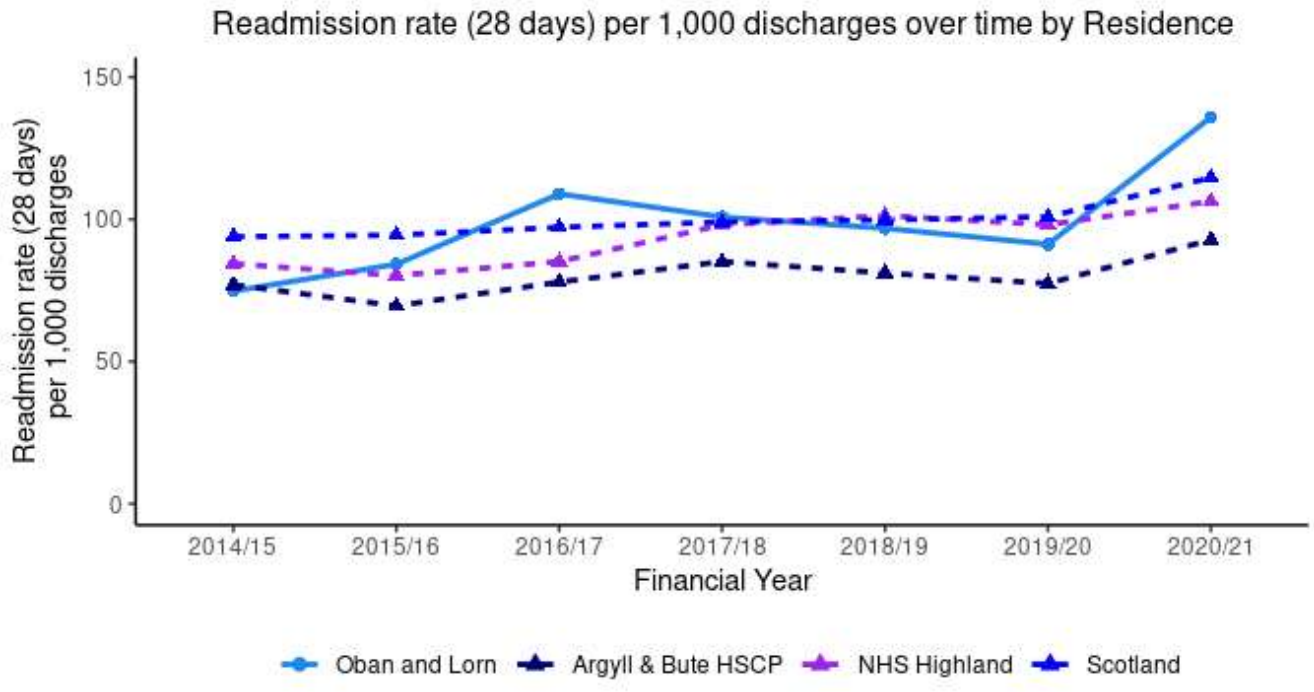
Emergency Readmissions (28 days)

Figure 35: Emergency readmissions by age group



Source: PHS SMR01

Figure 36: Emergency readmissions by geographical area

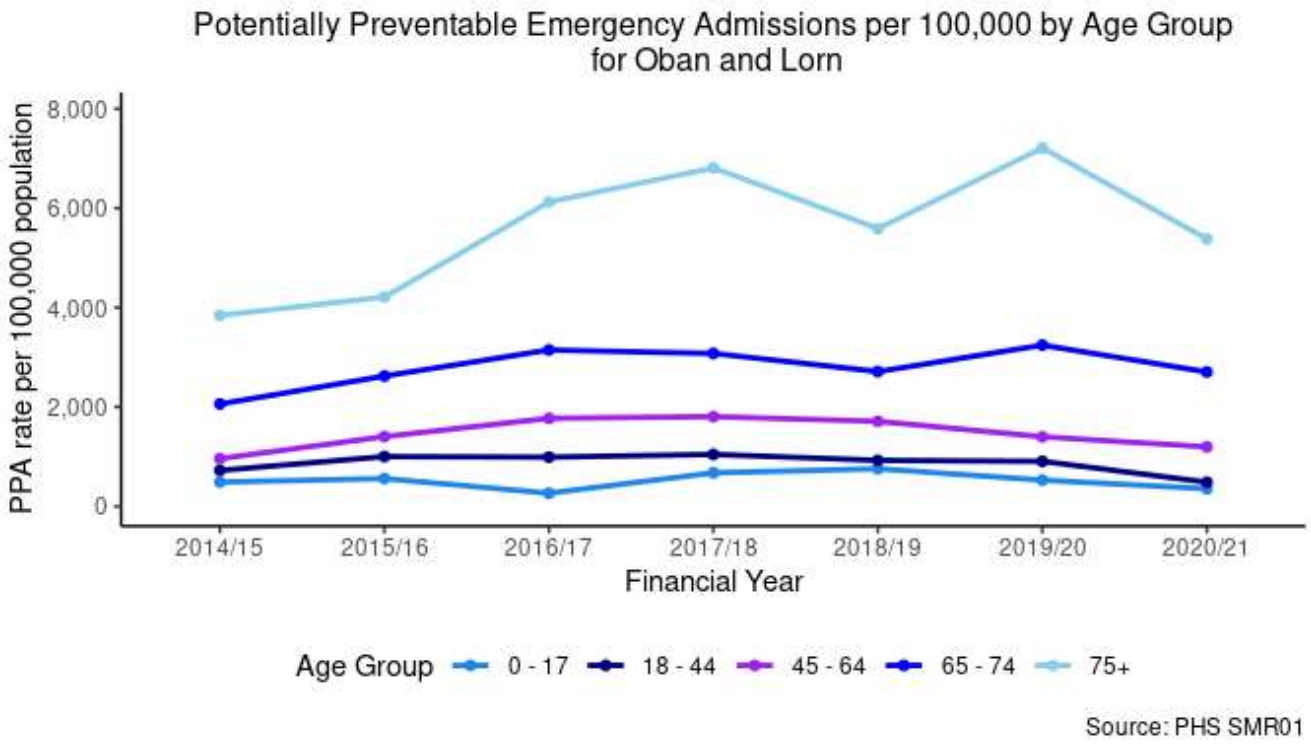


Source: PHS SMR01

Potentially Preventable Admissions (PPAs)

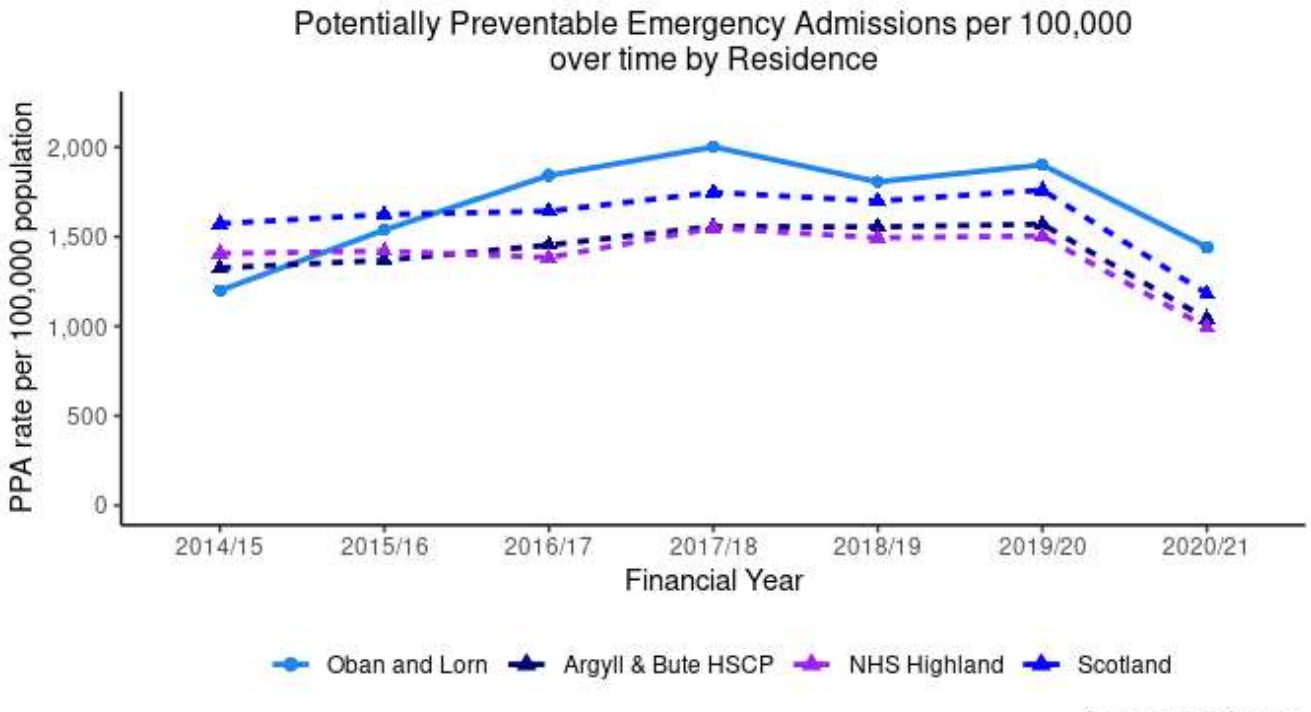
Information on which conditions are counted as PPAs is available in Appendix 3 in the accompanying summary document.

Figure 37: PPAs by age group



Source: PHS SMR01

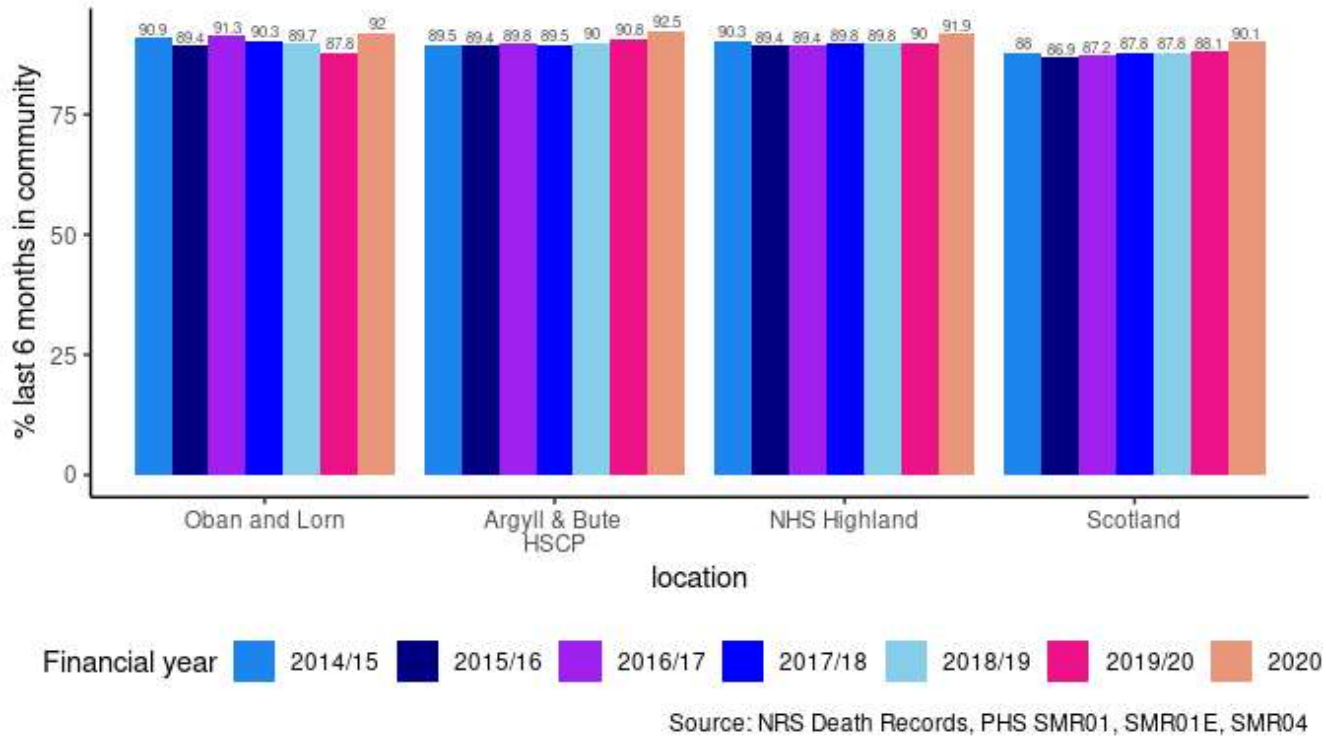
Figure 38: PPAs by geographical area



Source: PHS SMR01

% Last 6 months in a Community Setting

Figure 39: Last 6 months in a community setting by geographical area



Source: NRS Death Records, PHS SMR01, SMR01E, SMR04

Footnotes

1. Population projections are not currently provided by NRS at the locality level. To explore how the population in Oban and Lorn is expected to change in the future, the percent changes in population projection to 2025 for Argyll and Bute by age group and gender were calculated from the NRS Local Authority Population Projections. These percent changes were then applied to the Oban and Lorn 2018 mid-year population estimates (also split by age group and gender) to obtain population projection estimates for Oban and Lorn, based on the projections for the HSCP and the current population structure of the locality.
2. Care Home Data included in the Services Map and Table was sourced from the Care Inspectorate. GP Practice data from October 2021, and Hospital and A&E data was sourced from Public Health Scotland Open Data. Only services that are within the physical boundary of the HSCP or Locality are included in the map and table, so there may be services outside Argyll and Bute which people may use but are not shown.
3. The data used in General Health and Behavioural Factors sections (except for long-term conditions) of this locality profile are taken from ScotPHO. There may be more recent data available for the indicators elsewhere.
4. Data taken from ScotPHO is often reported using the European Age-Sex Standardised Rate per 100,000. This allows for comparisons across different areas to be made. For more information on how these rates are calculated, please refer to www.isdscotland.org/Products-and-Services/GPD-Support/Population/Standard-Populations/
5. Physical long-term conditions data comes from the Source Linkage Files, and the conditions are identified using ICD-9 and ICD-10 codes in the diagnosis fields. Please note that the Source Linkage Files data only contains information on people who have had contact with the NHS through either inpatient admissions, outpatient attendances, daycase attendances, A&E attendances or through prescribed items, the data does not show all service users in Scotland who have been diagnosed with an LTC as not all of these individuals will have used these services. Also note that LTC rates are based on an adjusted population indicator in the Source Linkage Files so that population sizes are closer to the official estimates.
6. The 2020 COVID-19 pandemic will have had an effect on the most recent data available. A dashboard has been created by PHS which show the wider impacts of COVID-19 over many areas. You can access this here: https://scotland.shinyapps.io/phs-covid-wider-impact/

Locality Profile

Mull Iona Coll and Tiree Locality

October 2021

Table of Contents

Notes for this profile:

- All years shown are calendar years unless otherwise specified.
- Upper and lower 95% confidence intervals are shown throughout this document where available. In charts, these are displayed as shaded areas either side of trend lines, or as black error bars in bar charts. Confidence intervals show the range of possible values and a certainty that the true value falls within them.
- Definitions for the indicators shown are available in Appendix 1 in the accompanying summary document.
- Any zero figures for some indicators will indicate either suppression of small data or a complete lack of data available for this locality
- Data should be interpreted with caution, particularly for areas with relatively small population sizes where indicator data is expected, by chance alone, to have higher variation than in areas of larger population size. Note that differences between areas can relate to multiple factors including, for example, underlying rates of illness, rates of diagnosis and local differences in practice e.g. in data recording.

Demographics

Summary:

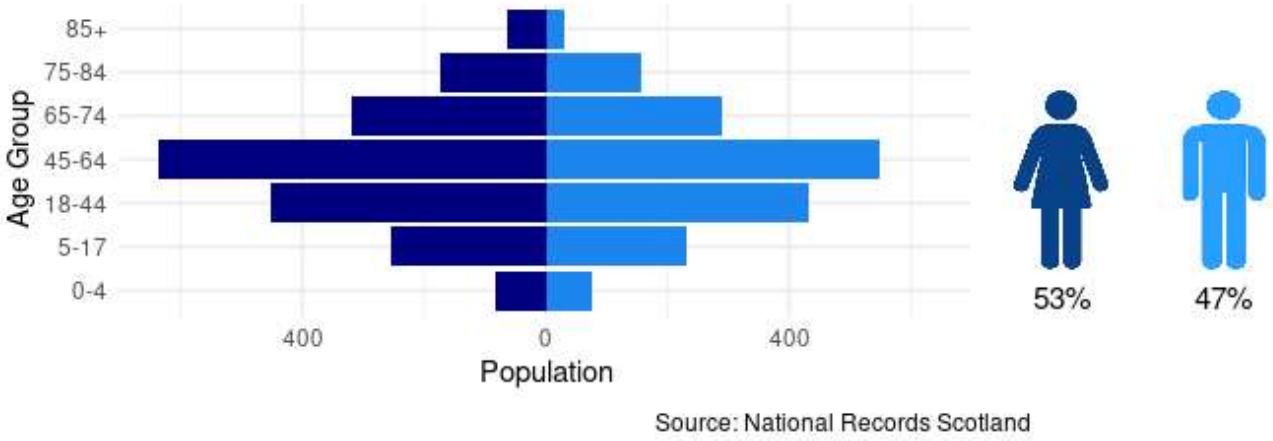
For the most recent time periods available, Mull Iona Coll and Tiree Locality had:

- A total population of **3,747** people, where **47%** were male, and **28%** were aged over 65.
- **0%** of people lived in the least deprived SIMD quintile, and **0%** lived in the most deprived quintile.

Population

In 2020, the total population of Mull Iona Coll and Tiree locality was 3,747. The graph below shows the population distribution of the locality.

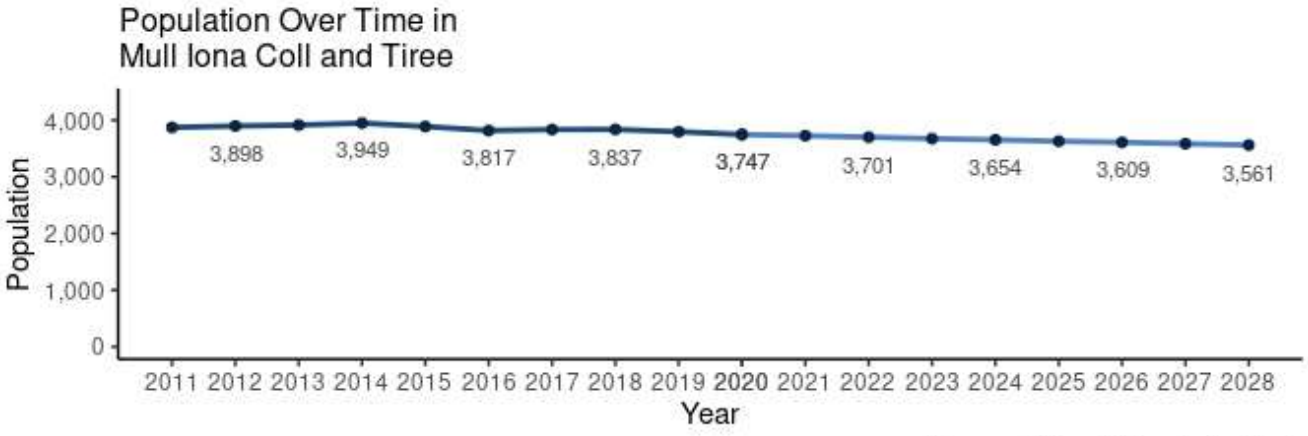
Figure 1: Population breakdown in Mull Iona Coll and Tiree.



Source: National Records Scotland

Figure 2 shows the historical population of Mull Iona Coll and Tiree, along with the NRS population projections. The population has been falling. The population in Mull Iona Coll and Tiree is estimated to decrease by 3.1% from 2020 to 2025 *Please see the footnotes for more information on how the population projections were calculated*[1].

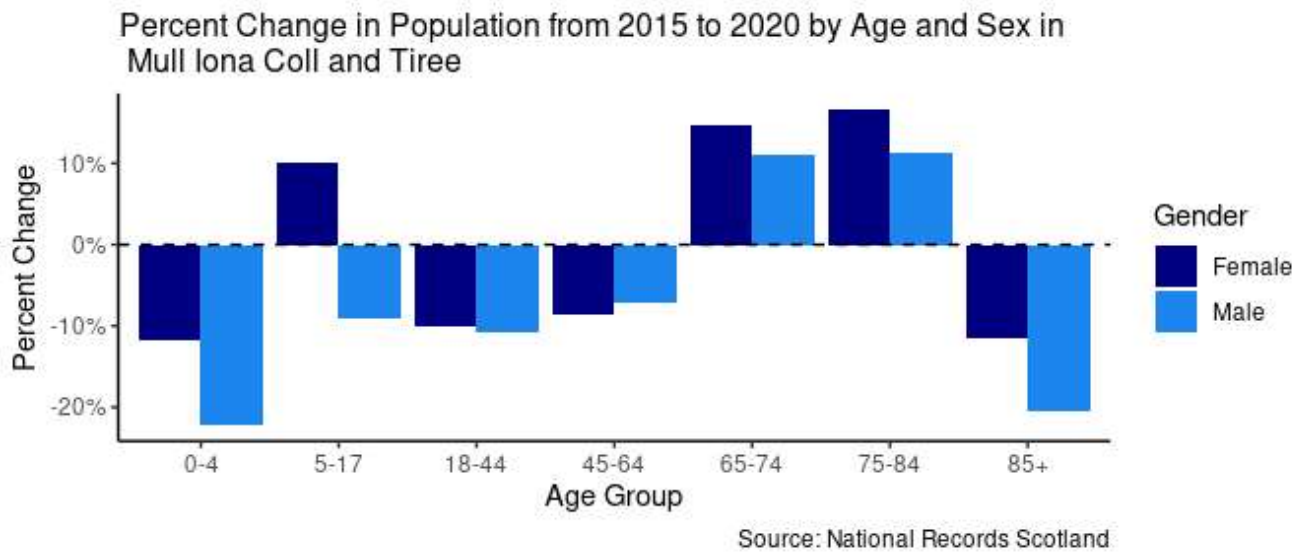
Figure 2: Population time trend and projection.



Source: National Records Scotland

Figure 3 shows how population structure has changed between 2015 and 2020.

Figure 3: Change in population structure over the last five years.



Deprivation

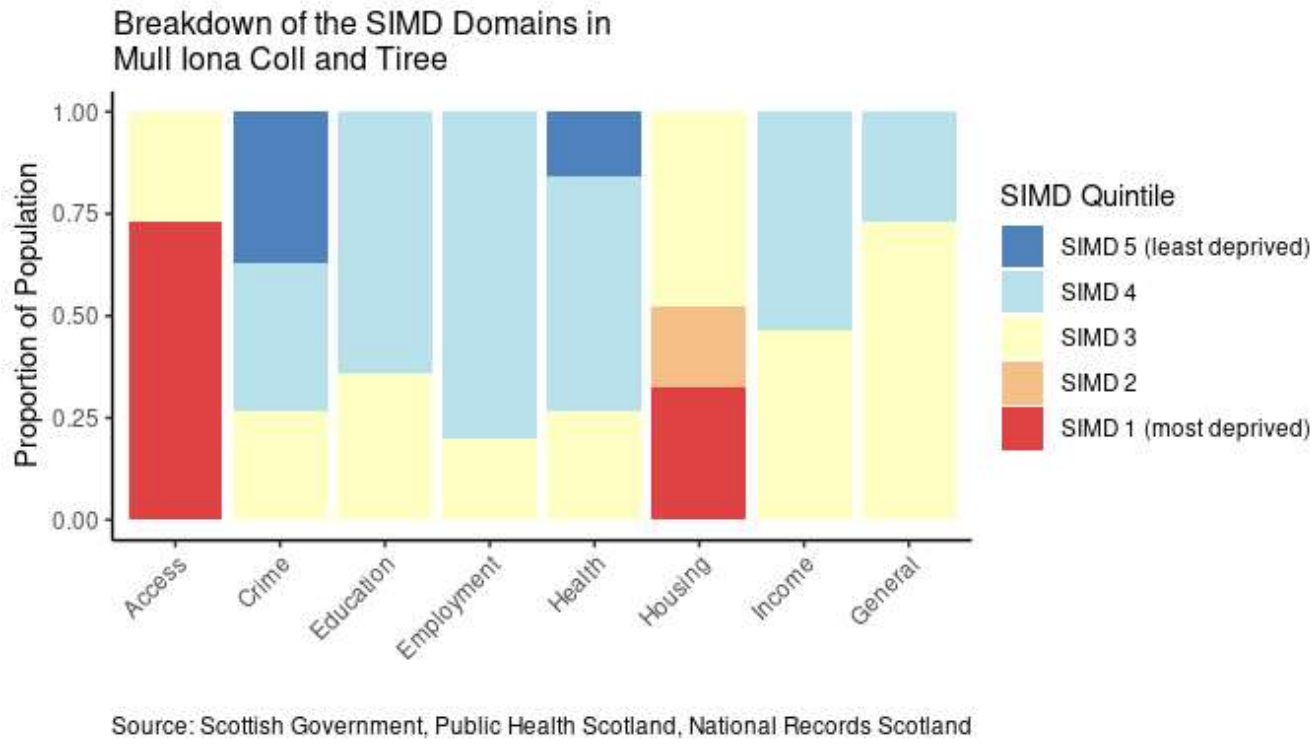
The following section explores the deprivation structure of Mull Iona Coll and Tiree through the Scottish Index of Multiple Deprivation (SIMD). The SIMD ranks all datazones in Scotland by a number of factors; Access, Crime, Education, Employment, Health, Housing and Income. Based on these ranks, each datazone is then given an overall deprivation rank, which is used to split datazones into Deprivation Quintiles (Quintile 1 being the most deprived, and Quintile 5 the least). The most recent SIMD ranking was carried out in 2020. This section mainly focuses on the SIMD 2020 classifications, however the 2016 classifications are used to assess how deprivation has changed in Mull Iona Coll and Tiree when compared to the rest of Scotland.

Of the 2020 population in Mull Iona Coll and Tiree, **0%** live in the most deprived SIMD Quintile, and **0%** live in the least deprived SIMD Quintile. The following table details the percent of the population living in the 2016 SIMD Quintiles, the percent living in the 2020 SIMD Quintiles, and their difference for comparison.

Table 1: Percentage population living in the 2016 and 2020 SIMD Datazone Quintiles

Quintile	Percent of Pop (2016)	Percent of Pop (2020)	Difference
SIMD 1	0.0%	0.0%	0.0%
SIMD 2	0.0%	0.0%	0.0%
SIMD 3	73.5%	73.3%	-0.2%
SIMD 4	26.5%	26.7%	0.2%
SIMD 5	0.0%	0.0%	0.0%

Figure 4: Proportion of the population that reside in each 2020 SIMD quintile by domain.



Source: Scottish Government, Public Health Scotland, National Records Scotland

Households

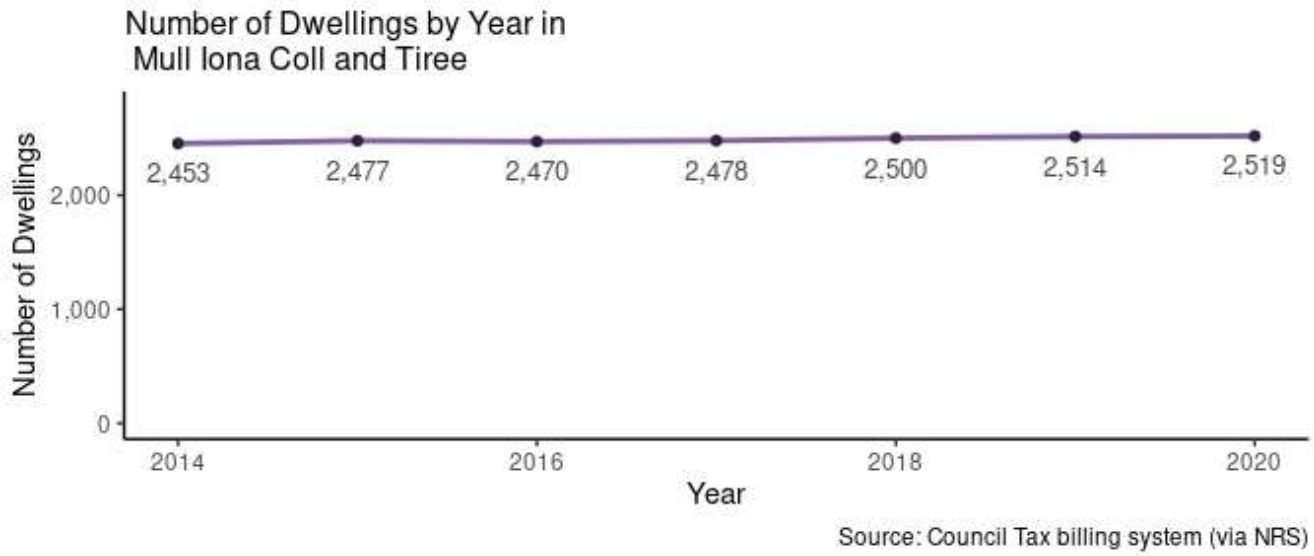
Summary:

For the most recent time periods available, Mull Iona Coll and Tiree Locality had:

- **2,519** dwellings, of which: **80%** were occupied and **14%** were second homes.
- **28%** of dwellers received a single occupant council tax discount, and **0.87%** were exempt from council tax entirely.
- **50%** of houses were within council tax bands A to C, and **17%** were in bands F to H.

The graph below shows the number of dwellings in Mull Iona Coll and Tiree from 2014 to 2020.

Figure 5: Number of dwellings time trend.



Of the total number of dwellings in 2020, 28% (714 households) were occupied by an individual receiving a single occupant council tax discount. Furthermore, 0.87% (22 households) were occupied and exempt from council tax.

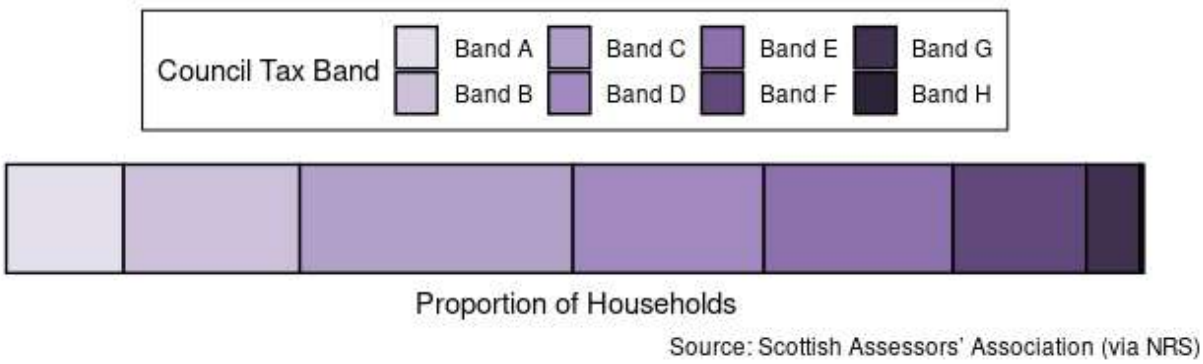
There were 362 dwellings classed as a second home in 2020, these dwellings made up 14% of the households in Mull Iona Coll and Tiree.

Table 2: Breakdown of dwelling types by year for Mull Iona Coll and Tiree locality.

Year	Total Dwellings	Occupied Dwellings	Vacant Dwellings	Single Occupant Tax Discount	Council Tax Exempt Dwellings	Second Homes
2014	2,453	1,941	129	702	20	382
2015	2,477	1,957	130	687	17	390
2016	2,470	1,974	107	684	20	388
2017	2,478	2,005	104	701	22	368
2018	2,500	2,018	124	682	17	358
2019	2,514	2,023	131	687	19	360
2020	2,519	2,026	132	714	22	362

The proportion of households within each council tax band are displayed in the chart below, figures are shown in Table 3.

Figure 6: Breakdown of households by council tax band for Mull Iona Coll and Tiree in 2020.



Source: Scottish Assessors' Association (via NRS)

Table 3: Percentage of households by council tax band for Mull Iona Coll and Tiree in 2020.

Tax Band	A	B	C	D	E	F	G	H
Percent of households	10%	15%	24%	17%	17%	12%	4.7%	0.32%

General Health

Summary:

For the most recent time periods available[3], Mull Iona Coll and Tiree Locality had:

- **An average life expectancy of 76.9 years for males and 85.5 years for females.**
- **A death rate for ages 15 to 44 of 66 deaths per 100,000 age-sex standardised population[4]**
- **23%** of the locality's population with at least one long-term physical health condition.
- A cancer registration rate of **697** registrations per 100,000 age-sex standardised population[4]
- **18.57%** of the population being prescribed medication for anxiety, depression, or psychosis.

Life Expectancy

In the latest time period available from 2016-2020 (5 year aggregate), the average life expectancy in Mull Iona Coll and Tiree locality was 76.9 years old for men, and 85.5 years old for women. A time trend since 2013-2017 can be seen in figure 8.

Figure 8: Average life expectancy in men and women over time.

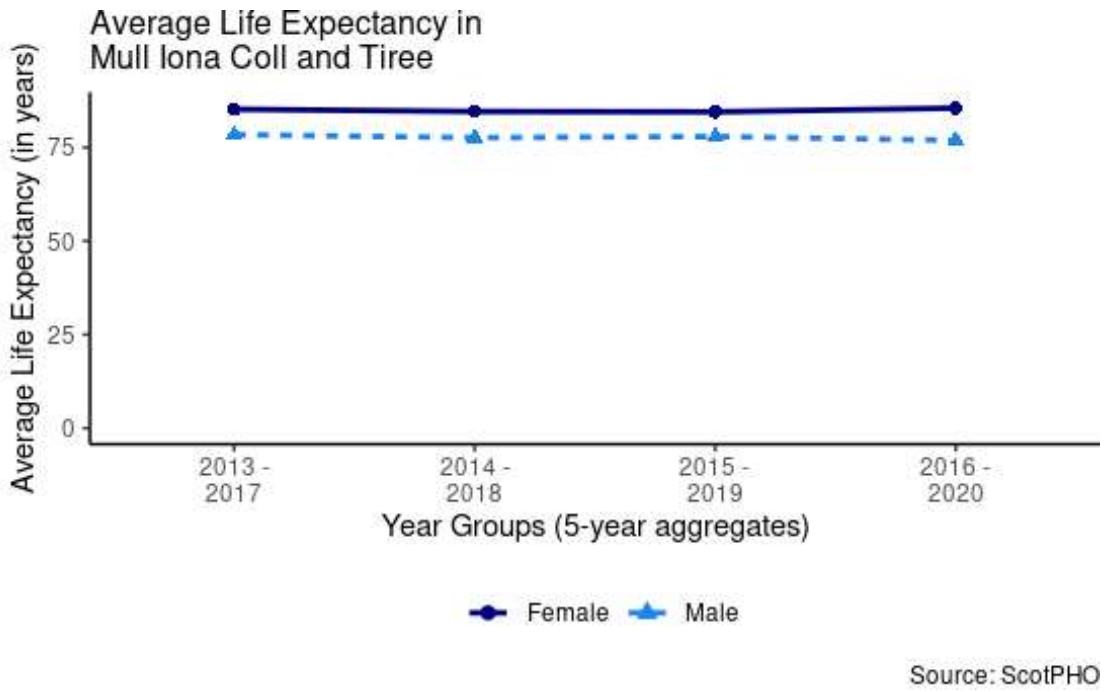


Table 5 provides the average life expectancy for men and women in different areas for the latest time period available. Please note that these are 5 year aggregates for the locality from 2016-2020, but 3 year aggregates from 2018-2020 at partnership, Health Board, and Scotland level.

Table 5: Average life expectancy in years for the latest time periods (2016-2020 aggregated years for the locality; 2018-2020 aggregated years for other areas).

	Locality	Partnership	Health Board	Scotland
	85.5	81.6	81.8	81
	76.9	78	77.6	76.8

Where Locality = Mull Iona Coll and Tiree, Partnership = Argyll and Bute HSCP, Health Board = NHS Highland.

Deaths, aged 15-44

The following chart shows a trend of death rates among 15-44 year olds per 100,000 age-sex standardised population[4] by area (i.e. Early mortality rate per 100,000). In the most recent aggregate time period available (from 2018-2020), the mortality rate in Mull Iona Coll and Tiree locality was **66** deaths per 100,000 population. Figure 10 then provides comparisons of deaths for all localities in Argyll and Bute HSCP, for the two latest time aggregates available.

Figure 9: Deaths aged 15-44 years by geographical area and over time.

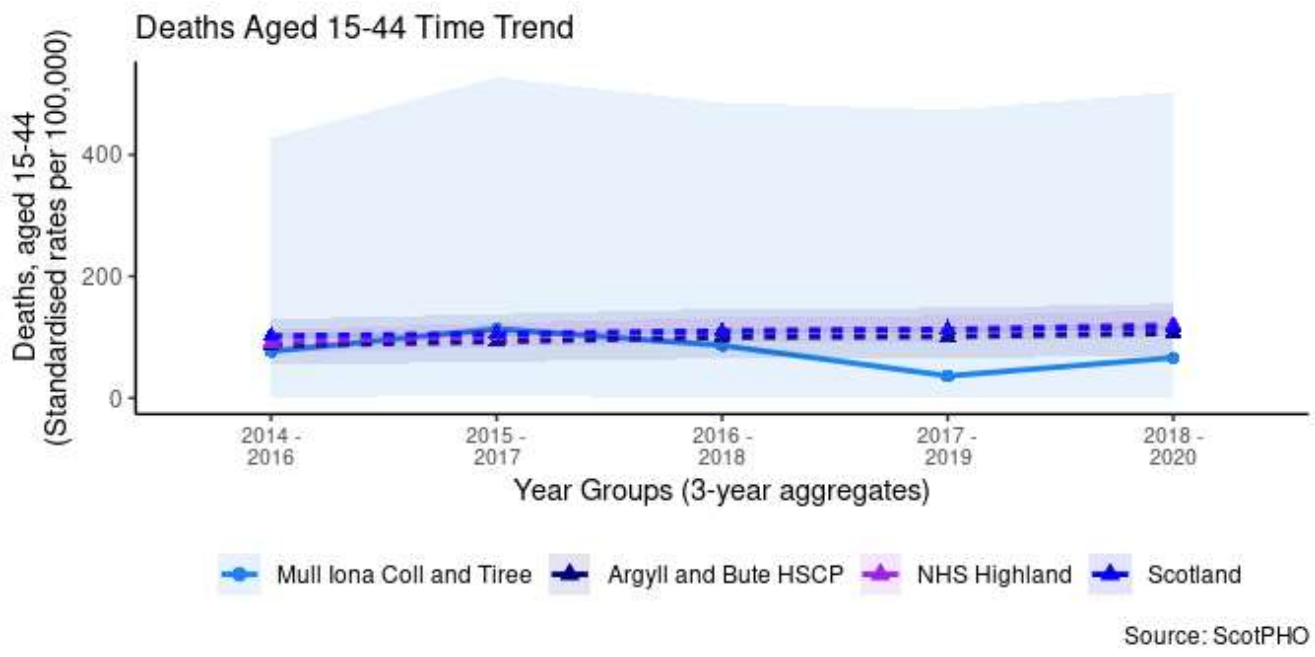
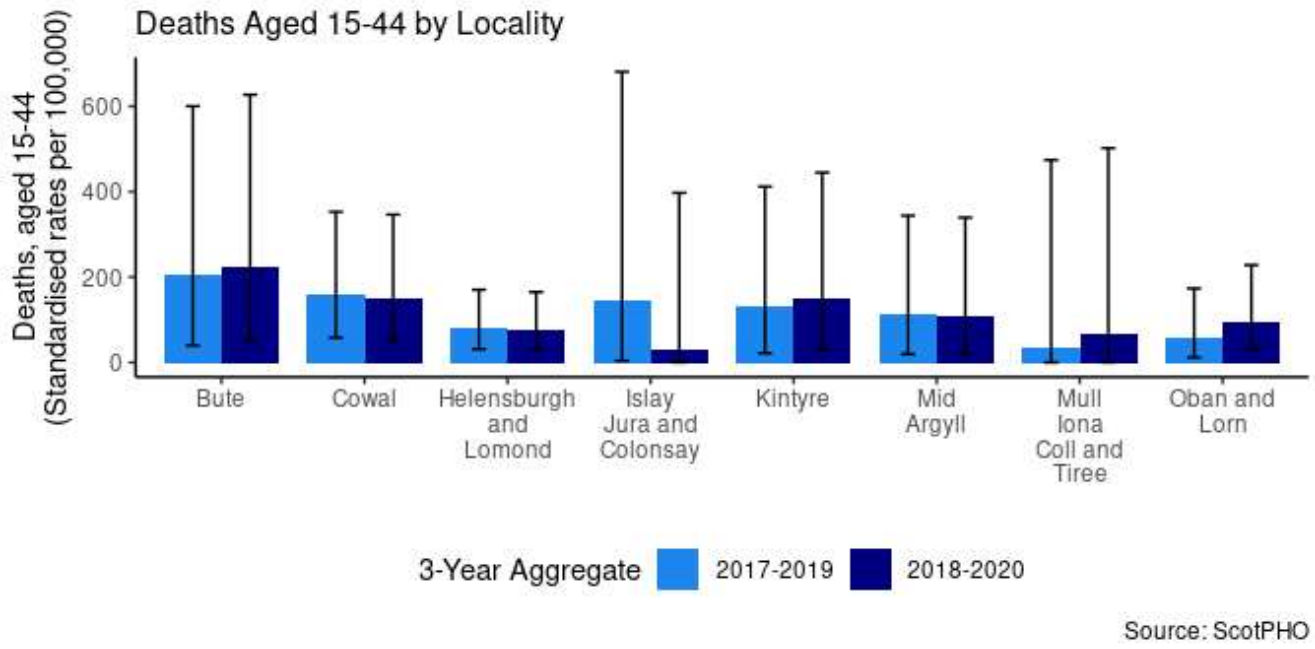
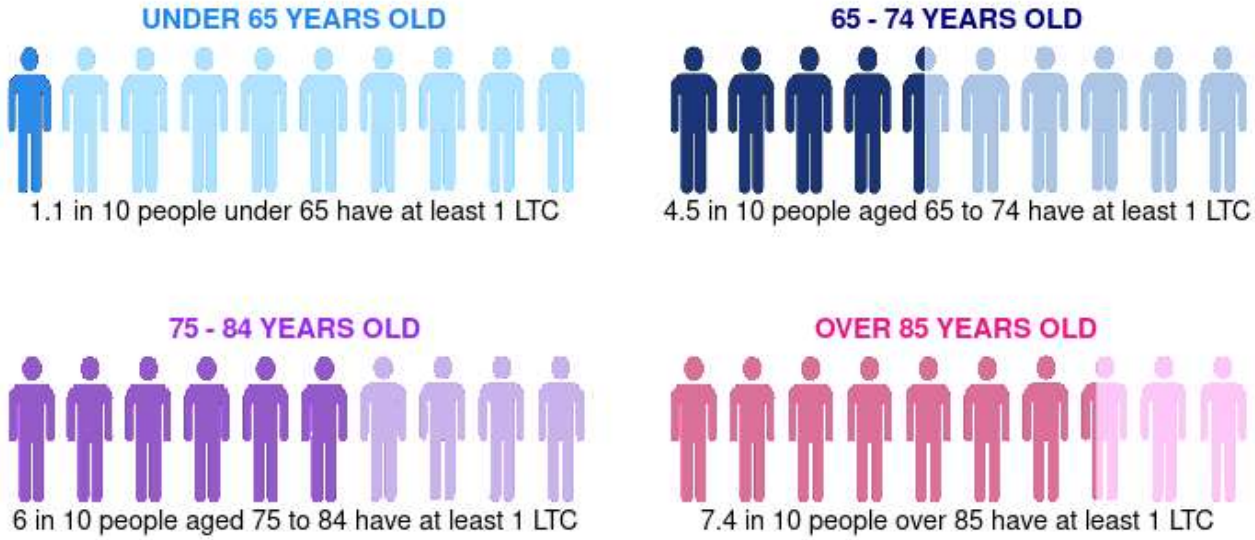


Figure 10: Deaths at ages 15-44 in Argyll and Bute HSCP localities.



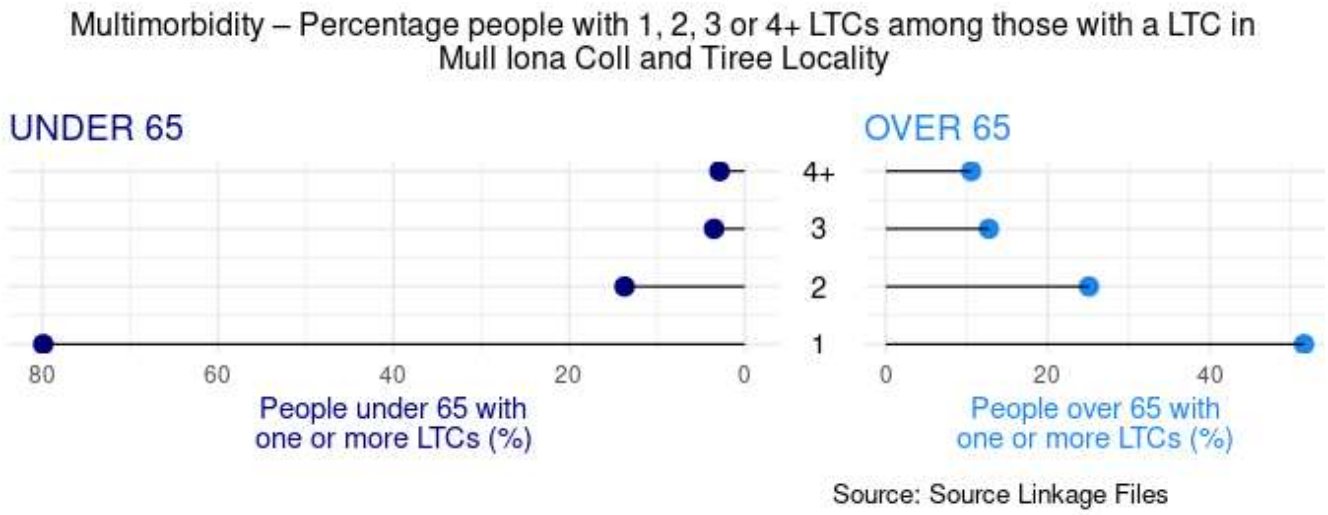
Long-Term Physical Health Conditions and Multimorbidity

In the financial year 2020/21, in Mull Iona Coll and Tiree Locality, **23%** of the total population had at least one physical long-term condition (LTC). These include: cardiovascular, neurodegenerative, and respiratory conditions, as well as other organ conditions (namely liver disease and renal failure), arthritis, cancer, diabetes, and epilepsy. *Please see footnotes for information and caveats on identifying LTCs.*[5]



The co-occurrence of two or more conditions, known as multimorbidity, is broken down in figure 11, distinguishing between age groups. Note that this chart *excludes* the population in the locality who do not have any physical long-term conditions. Figure 13 therefore shows that among the people who have a LTC, **20**% of those under the age of 65 have more than one, compared to **48**% of those aged over 65.

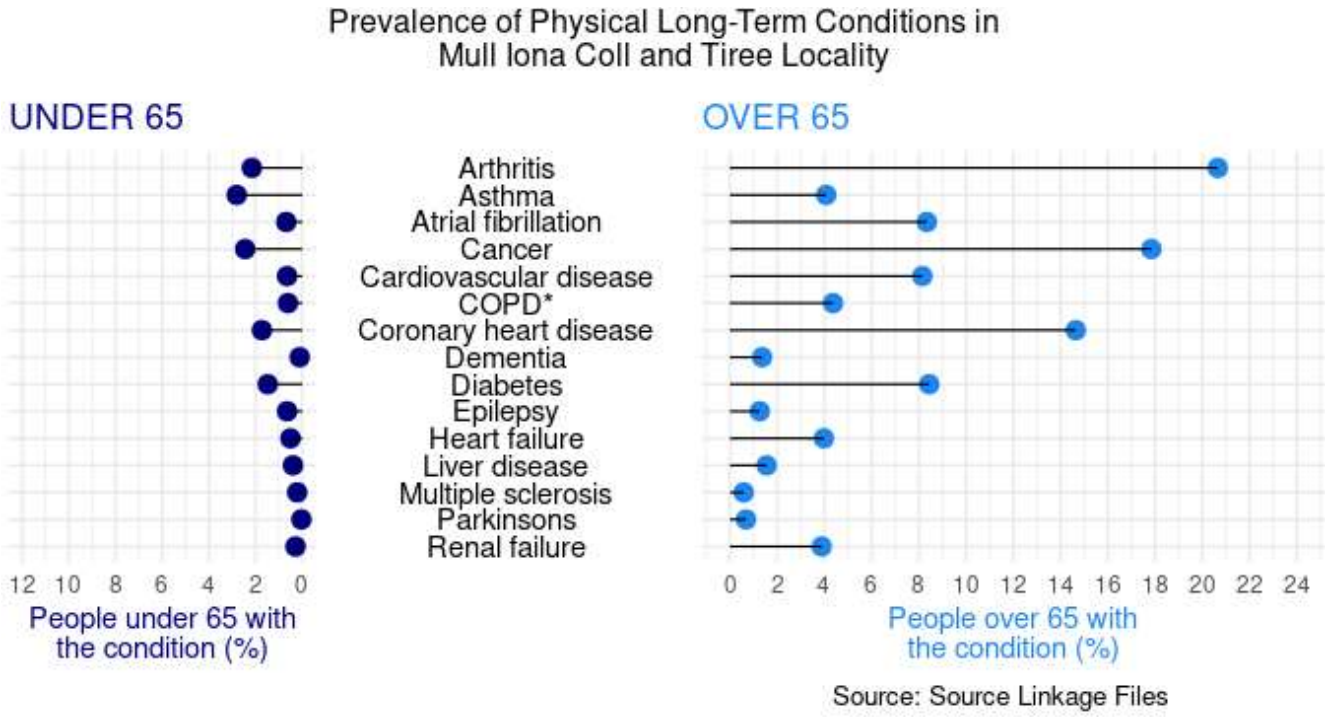
Figure 11: Multimorbidity of physical long-term conditions by age group in 2020/21.



Most common physical Long-Term Conditions (LTCs)

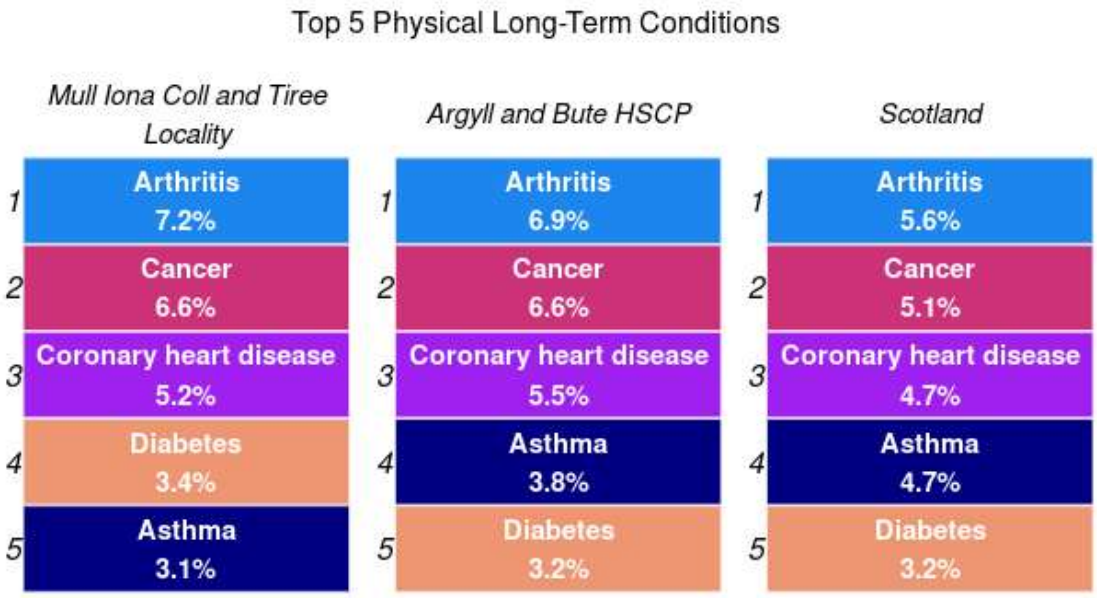
Below is a breakdown of the physical LTCs, for the financial year 2020/21. Figure 12 shows the prevalence of different LTCs in each age group in Mull Iona Coll and Tiree locality, and Table 6 illustrates the top 5 physical LTCs across all ages at locality, partnership, and Scotland level.

Figure 12: Percentage people with each physical LTC, split by age group.



**COPD: Chronic Obstructive Pulmonary Disease*

Table 6: Prevalence of the five most common physical LTCs as a percentage of the population across geographical areas (where 1 = most prevalent).



Cancer Registrations

For the period 2017-2019, there were 32 new cancer registrations per year on average (**697** registrations per 100,000 age-sex standardised population) in Mull Iona Coll and Tiree locality. This is a **19%** increase in cancer registrations rate from the previous aggregate period 2016-2018. Figure 13 shows changes over time since 2014-2016, and Figure 14 compares the rates of localities in Argyll and Bute HSCP for the two latest available time periods.

Figure 13: Cancer registration rate over time and by geographical area.

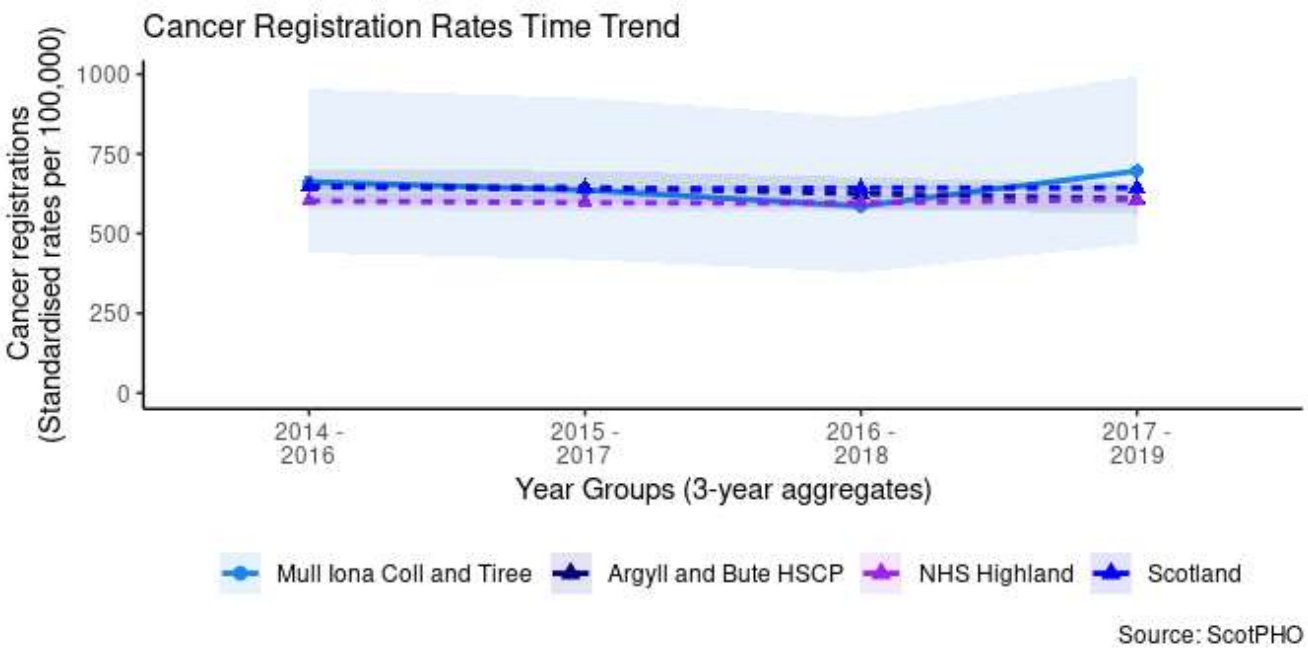
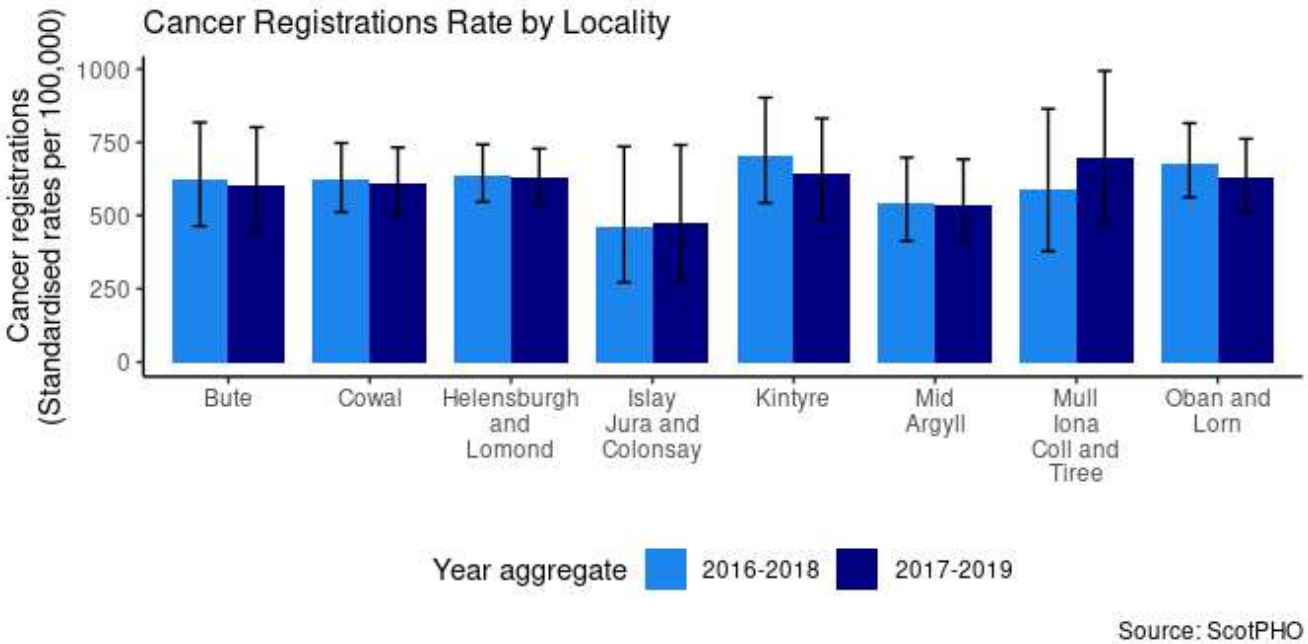


Figure 14: Cancer registration rates in Argyll and Bute HSCP localities.



Anxiety, Depression, and Psychosis Prescriptions

In the 2019/20 financial year, 18.57% of people were prescribed medication for anxiety, depression, or psychosis (ADP) in Mull Iona Coll and Tiree Locality. This is a 3.6% increase from the previous financial year. Differences over time and between areas may relate to multiple factors, only one of which is underlying disease. Note that data are based on main original licensed use for the prescriptions and some drugs included may be prescribed for other purposes.

Figure 15: Percentage population prescribed ADP medication in Argyll and Bute HSCP localities.

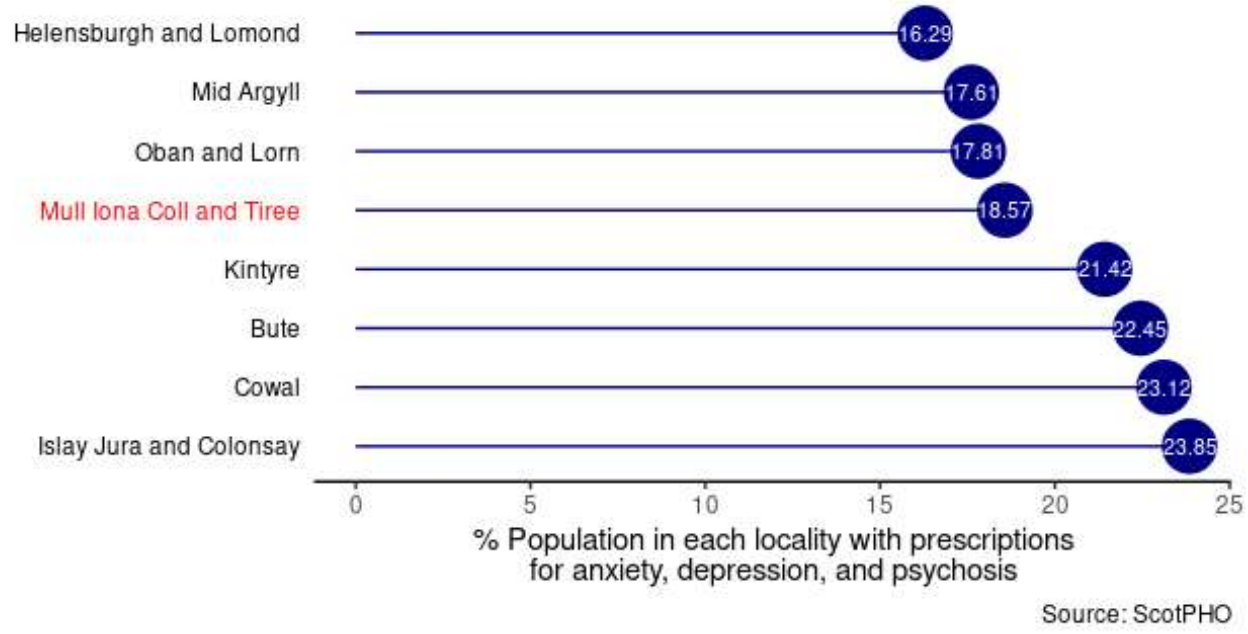
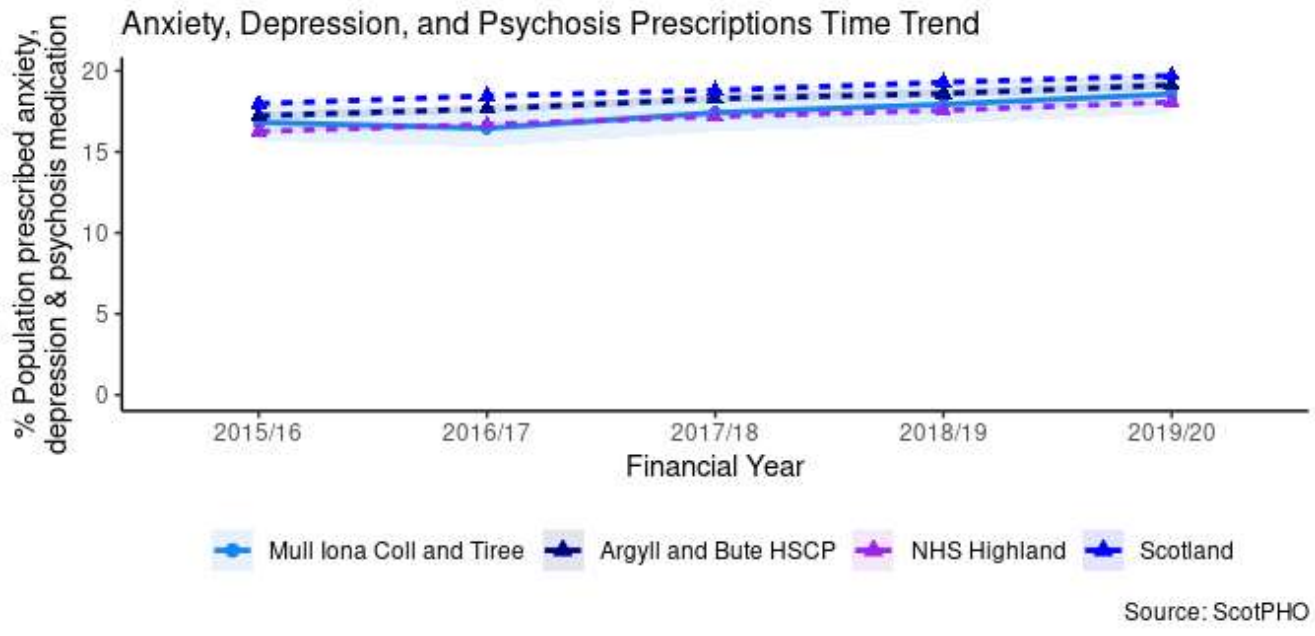


Figure 16: ADP prescriptions over time and by geographical area.



Bevioural Factors

Summary:

Mental and physical wellbeing has close ties with people's behaviours. Life circumstances including financial security, employment and location are interlinked with behavioural factors. This section provides data on drug-related hospital admissions, alcohol-related hospital admissions, alcohol-specific mortalities and bowel screening uptake, to give an overview of some behaviours known to be associated with health and wellbeing outcomes.

For the most recent time periods available[3], Mull Iona Coll and Tiree had:

- **18** drug-related hospital admissions per 100,000 age-sex standardised population[4]. This is a lower rate of admissions than for Scotland (221).
- **333** alcohol-related hospital admissions per 100,000 age-sex standardised population[4].
- **21** alcohol-specific mortalities per 100,000 age-sex standardised population[4].
- a **66%** uptake of bowel cancer screening for the eligible population.

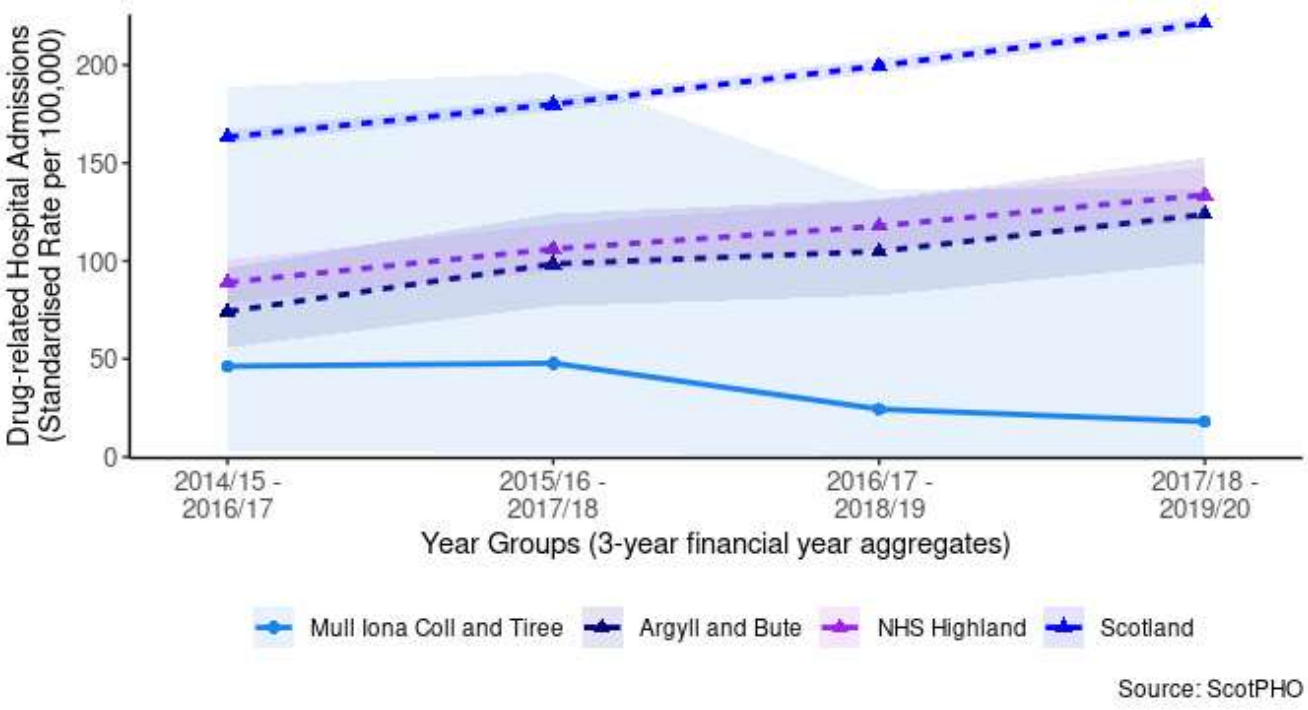
Drug-related Hospital Admissions

There were 18 drug-related hospital admissions per 100,000 age-sex standardised population[4] in Mull Iona Coll and Tiree locality for the most recent time period available (3 year financial year aggregate for 2017/18 - 2019/20).

This is a -61% decrease since 2014/15 - 2016/17 (3 financial year aggregates).

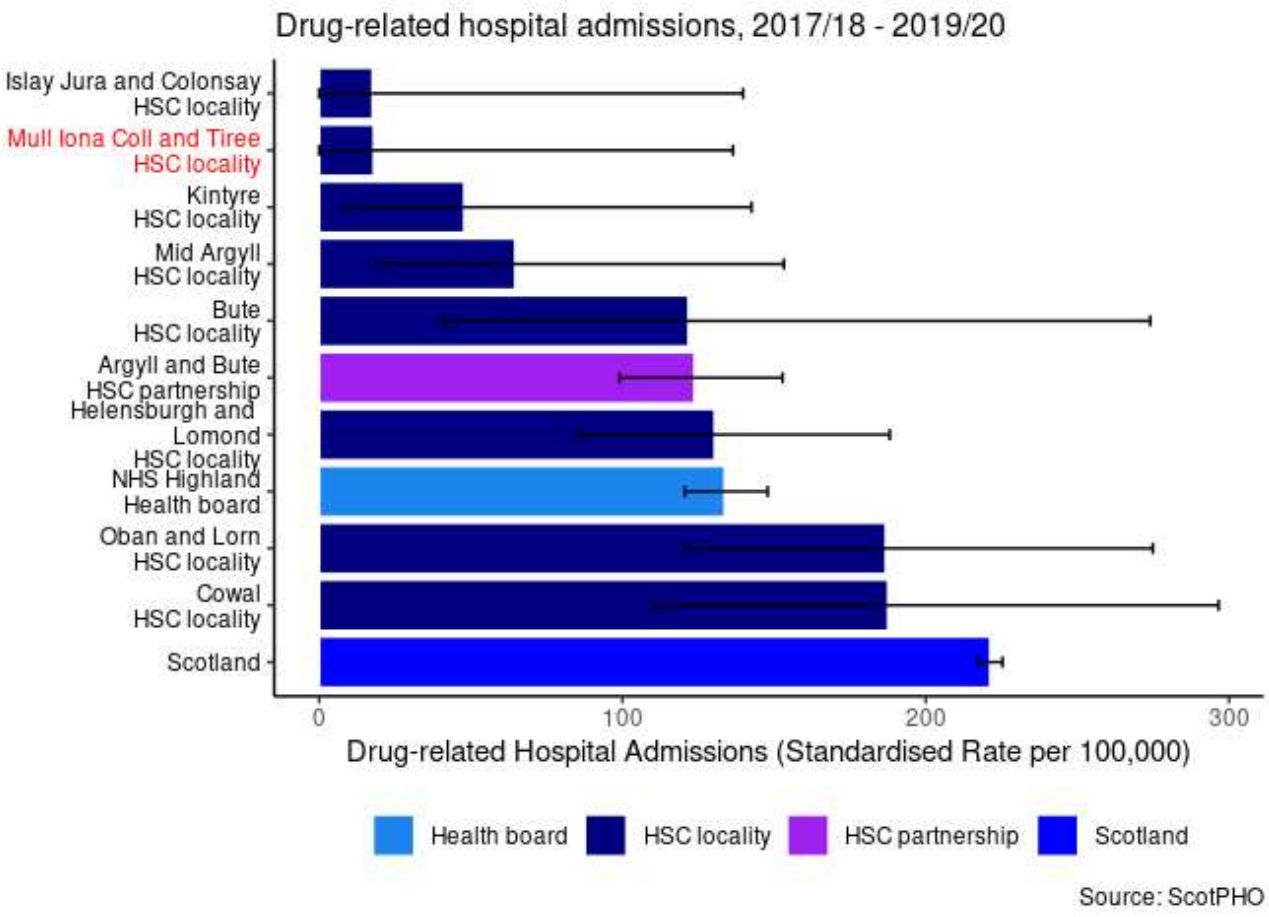
A trend of the change in drug-related hospital admissions for Mull Iona Coll and Tiree locality compared with Scotland, Argyll and Bute HSCP and NHS Highland is shown in the chart below from 2014/15 - 2016/17 onwards.

Figure 17: Trend of Drug-related Hospital Admission Rates by geographical area.



A comparison of areas at the most recent time period (2017/18 - 2019/20 aggregated financial years) is available below. This shows Mull Iona Coll and Tiree locality has a lower rate of admissions (18) than Argyll and Bute Partnership (124), and a lower rate of admissions than Scotland (221) overall.

Figure 18: Comparison of Drug-related Hospital Admission Rates for the period 2017/18 - 2019/20.

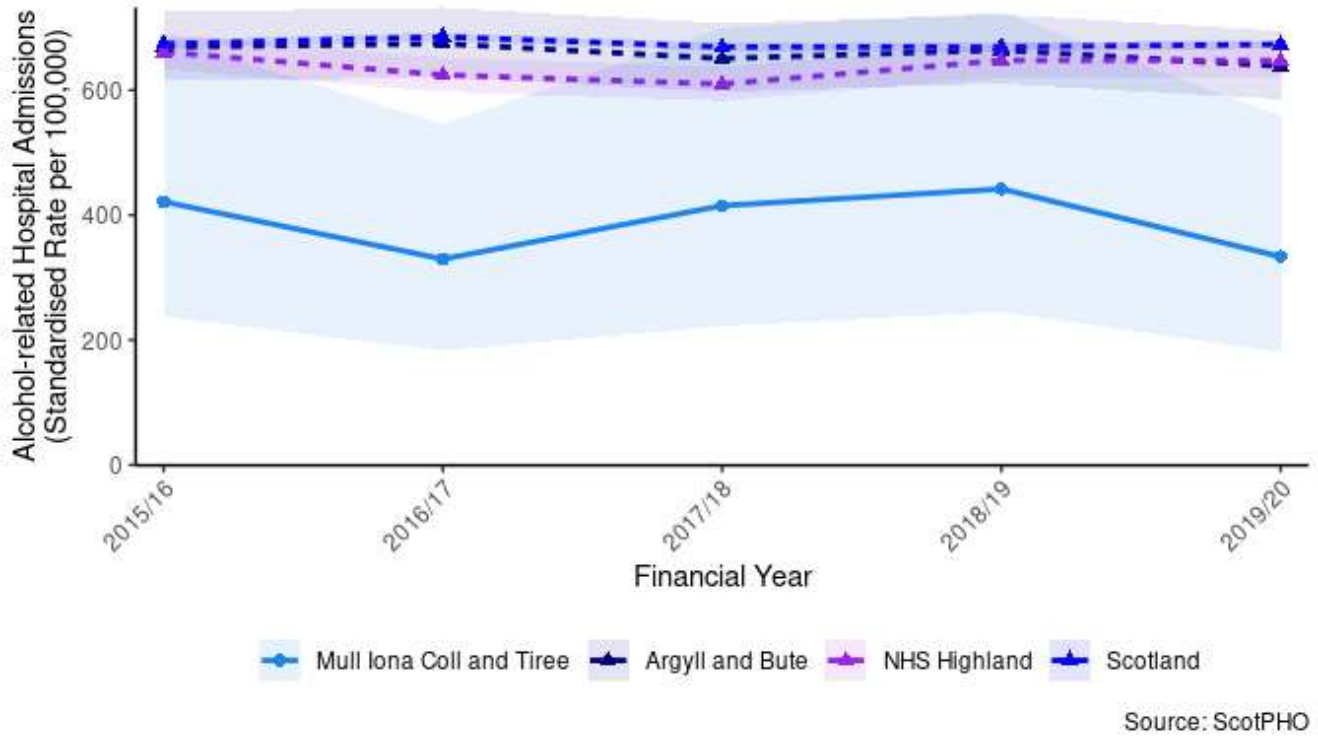


Alcohol-related Hospital Admissions

The 2019/20 alcohol-related admissions rate is 333 per 100,000 age-sex standardised population[4], which is a 21% decrease overall since 2015/16.

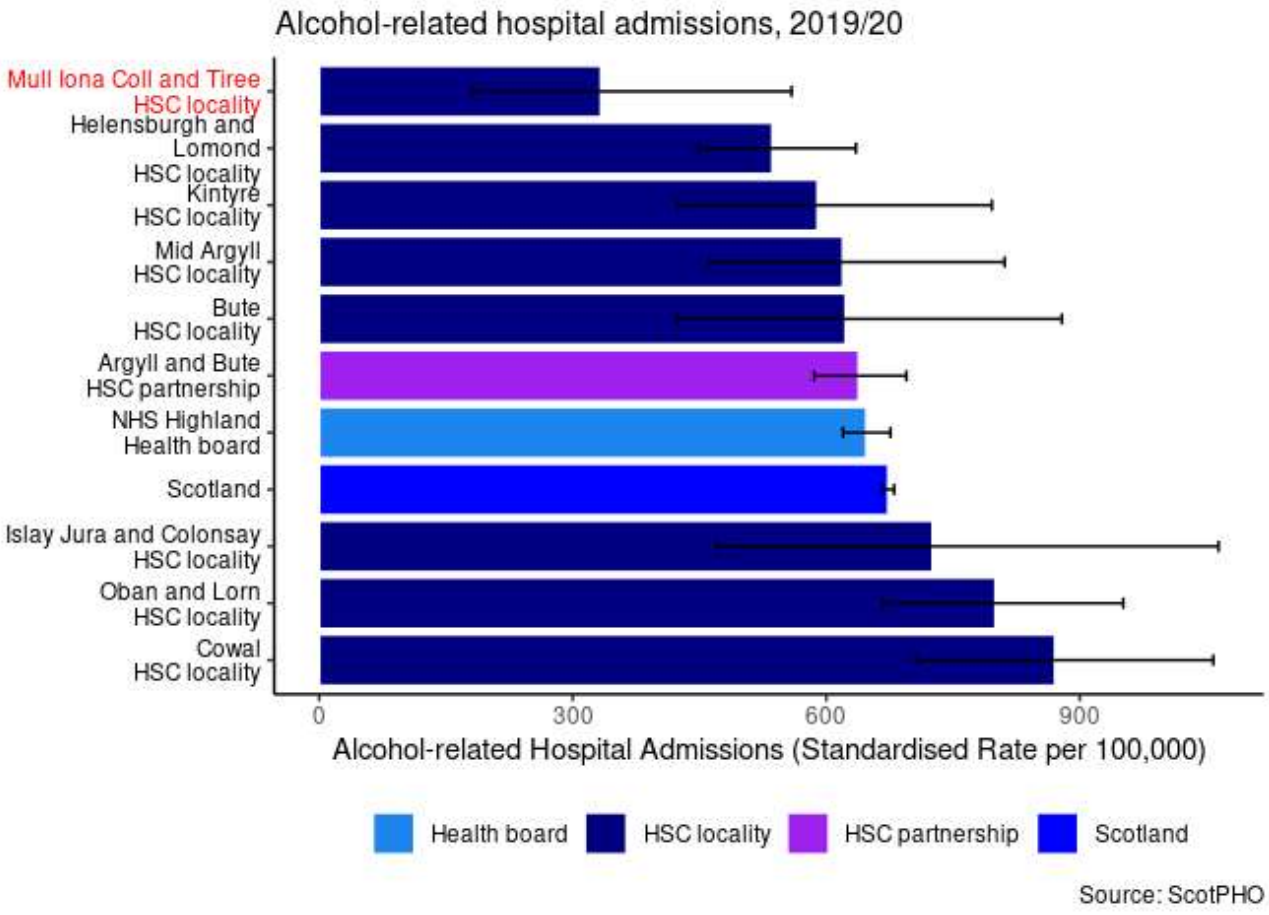
The chart below shows a trend of alcohol-related hospital admissions for Mull Iona Coll and Tiree locality compared with Scotland, Argyll and Bute Partnership and NHS Highland from financial year 2015/16 to 2019/20.

Figure 19: Trend of Alcohol-related Hospital Admission Rates by geographical area.



Comparison across different areas for 2019/20 is shown in Figure 20. This shows that Mull Iona Coll and Tiree locality had a lower alcohol-related hospital admissions rate (333) compared to Scotland (673).

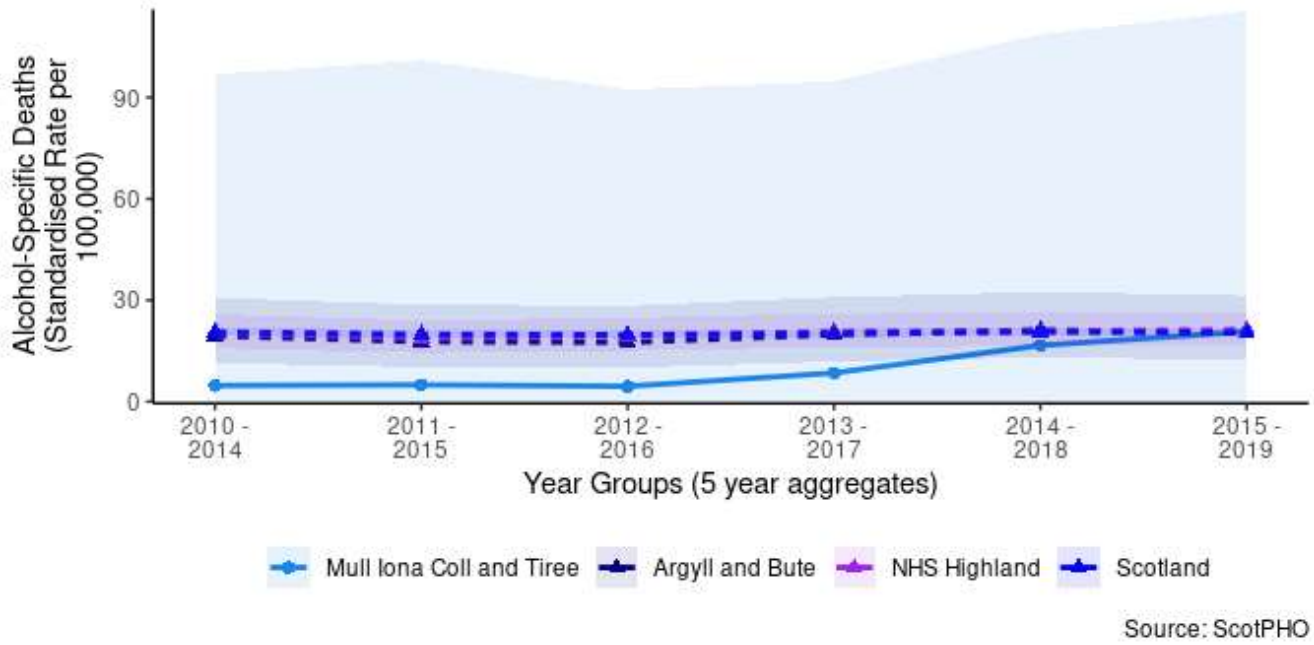
Figure 20: Comparison of Alcohol-related Hospital Admission Rates for 2019/20.



Alcohol-Specific Deaths

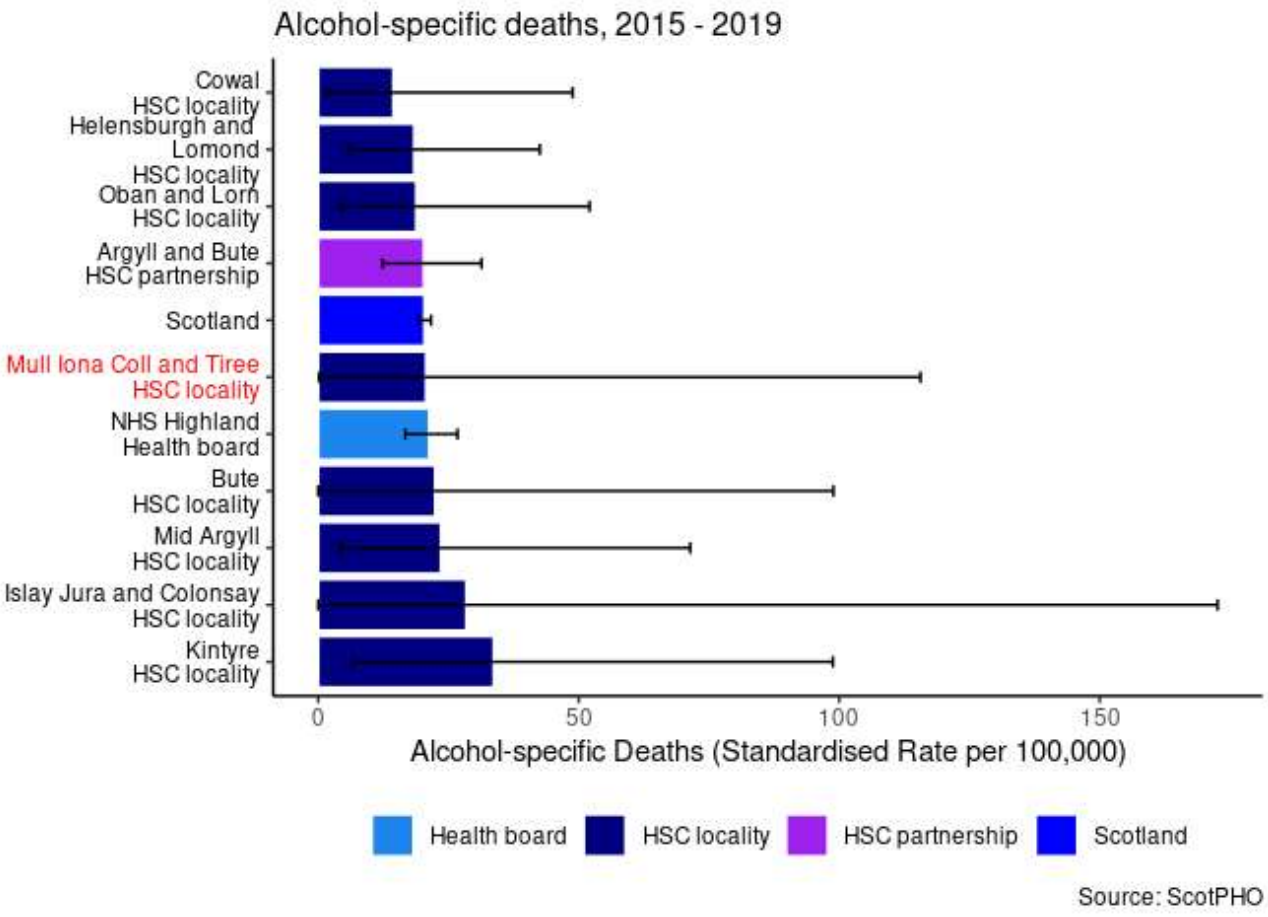
Data on alcohol-specific deaths is available as 5 year aggregates. The rate of alcohol-specific deaths is currently higher in Mull Iona Coll and Tiree than the rate in 2010 - 2014 (336% change).

Figure 21: Trend of Alcohol-Specific Death Rates by geographical area.



A comparison across different areas illustrates that Mull Iona Coll and Tiree locality has a higher alcohol-specific death rate compared to Scotland as a whole.

Figure 22: Comparison of Alcohol-related Death Rates for the period 2015 - 2019 (5 year aggregate).

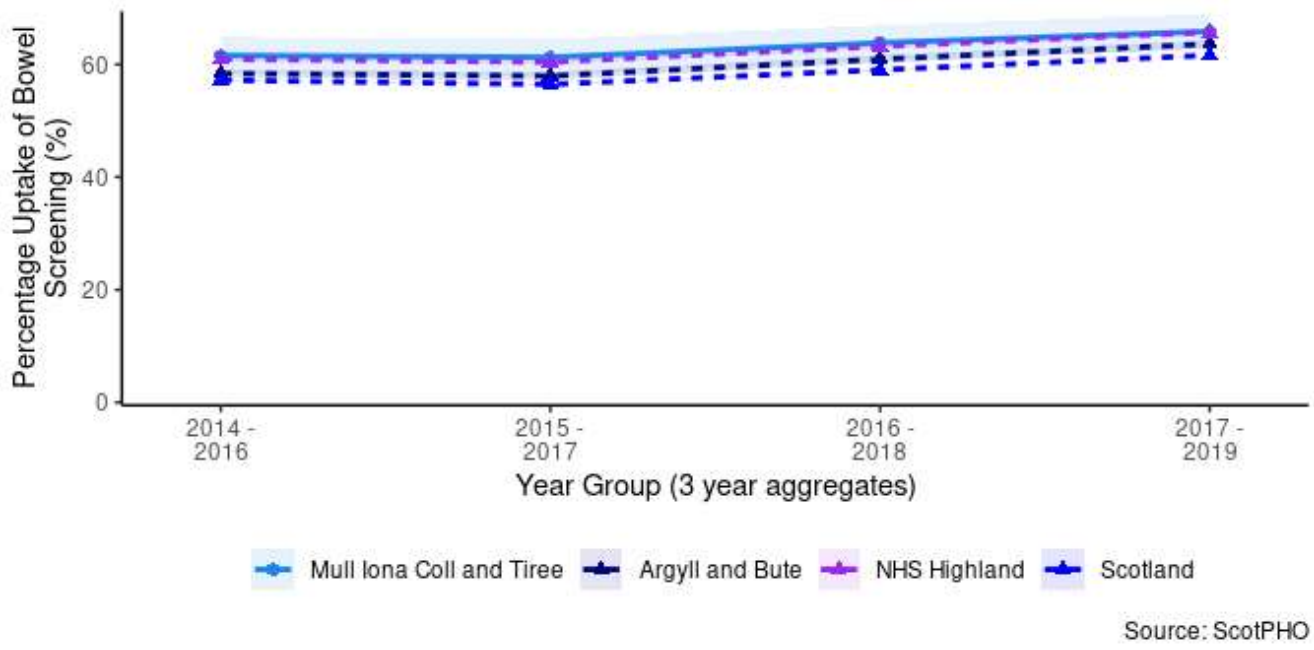


Bowel Screening Uptake

Bowel screening is offered every two years to eligible men and women aged between 50-74 years old. Eligible people are posted a test kit which is completed at home. Since 1st April 2013, those aged 75 and over can also self-refer and opt into screening.

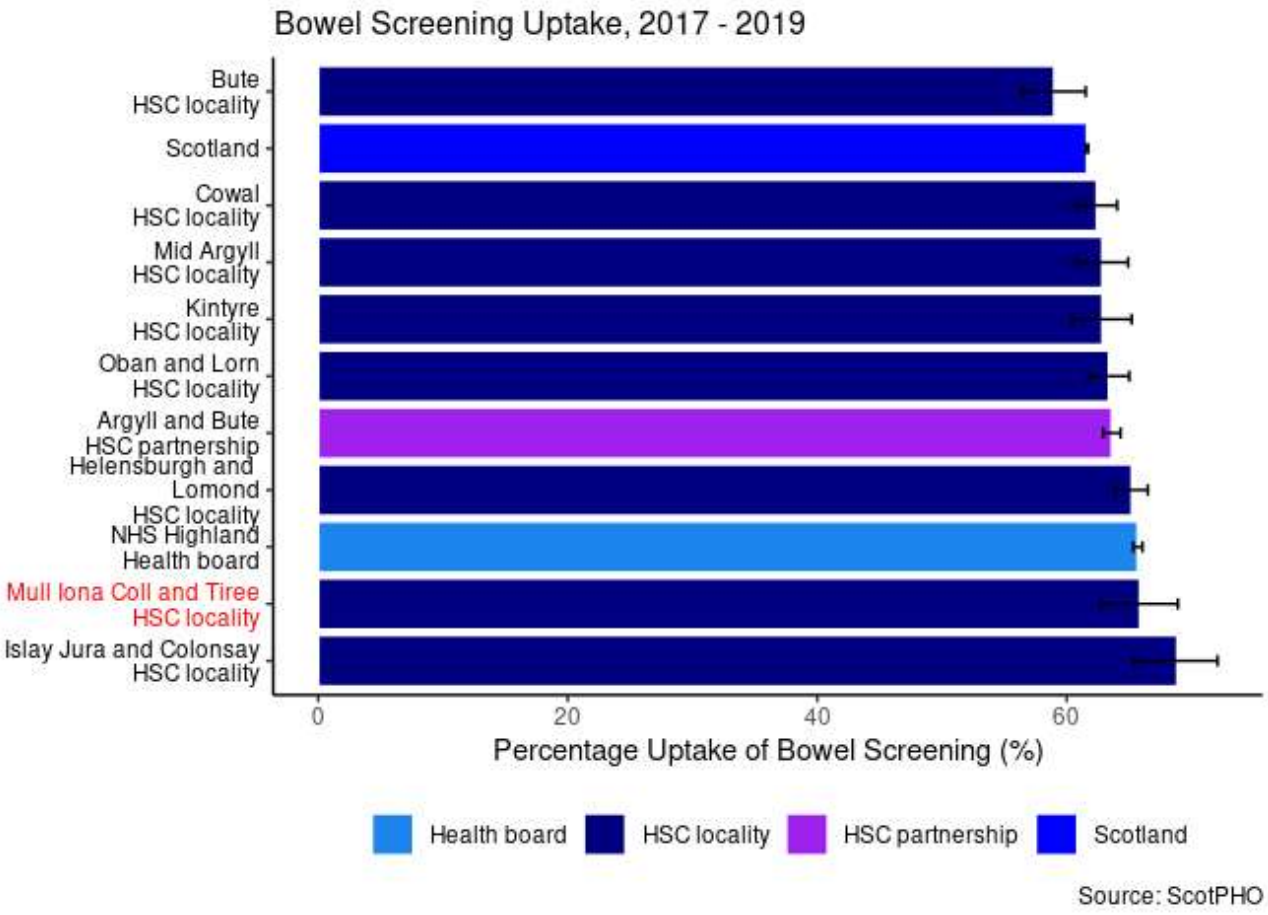
A trend of the percentage uptake of bowel screening among the eligible population is shown below for Mull Iona Coll and Tiree locality compared with Scotland, Argyll and Bute HSCP and NHS Highland. Data is suppressed into 3 year aggregates. The 2017 - 2019 uptake rate for Mull Iona Coll and Tiree is **66%**.

Figure 23: Trend of Bowel Screening Uptake for eligible men and women, by geographical area.



Compared with Scotland, Mull Iona Coll and Tiree locality has a higher percentage uptake of bowel cancer screening for the period 2017 - 2019.

Figure 24: Comparison of Bowel Screening Uptake for 2017 - 2019.



Hospital and Community Care

This section includes acute hospital data, delayed discharge bed days and A&E attendances. Please note that for 2020 onwards, hospital activity would have been severely affected by the COVID-19 pandemic. Information on how this has had a wider impact is provided in Footnote 6 at the end of the document.

For the most recent time periods available, Mull Iona Coll and Tiree had:

- **7,259** emergency hospital admissions per 100,000 population.
- **54,337** unscheduled acute specialty bed days per 100,000 population.
- **7,686** A&E attendances per 100,000 population.
- **7,767** delayed discharge bed days per 100,000 population.
- **934** emergency hospital admissions from falls per 100,000 population.
- **75** emergency readmissions (28 day) per 1,000 discharges.
- **827** potentially preventable hospital admissions per 100,000 population.
- People on average spent **94%** of their last 6 months of life in a community setting.

Emergency Admissions

Figure 25: Emergency admissions by age group

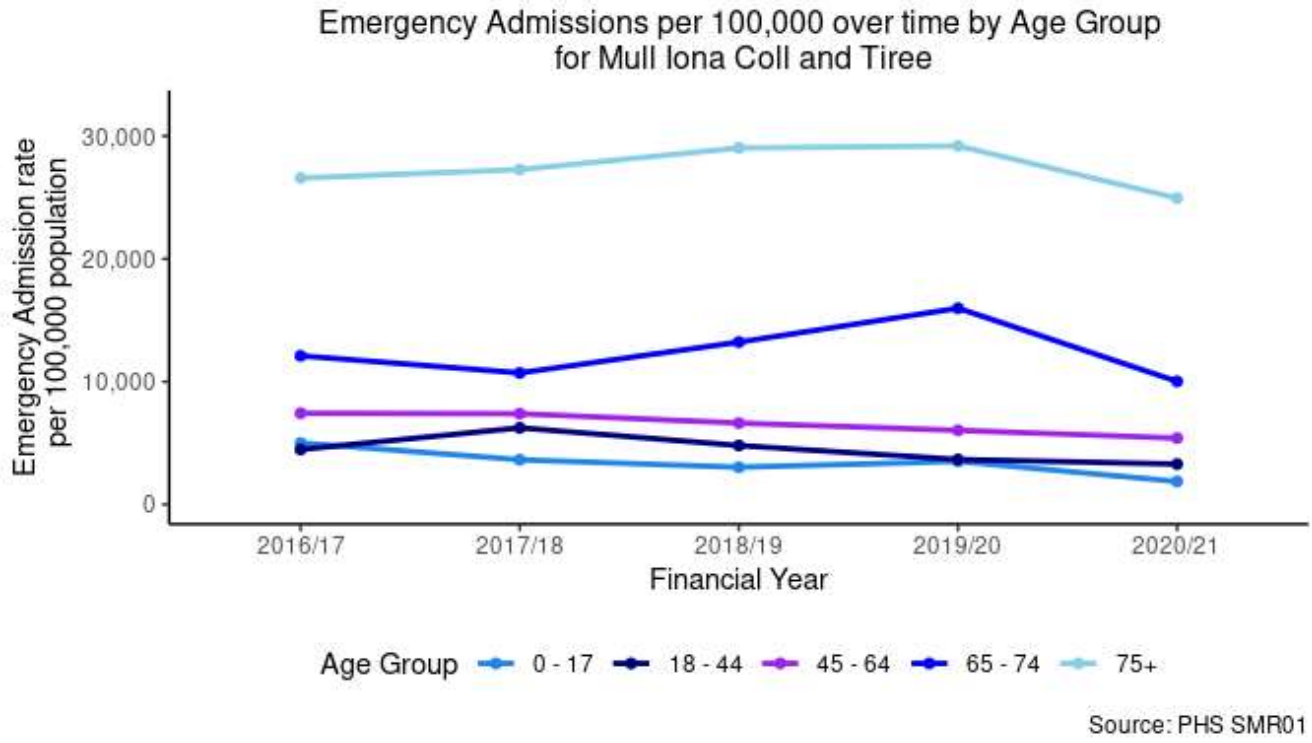
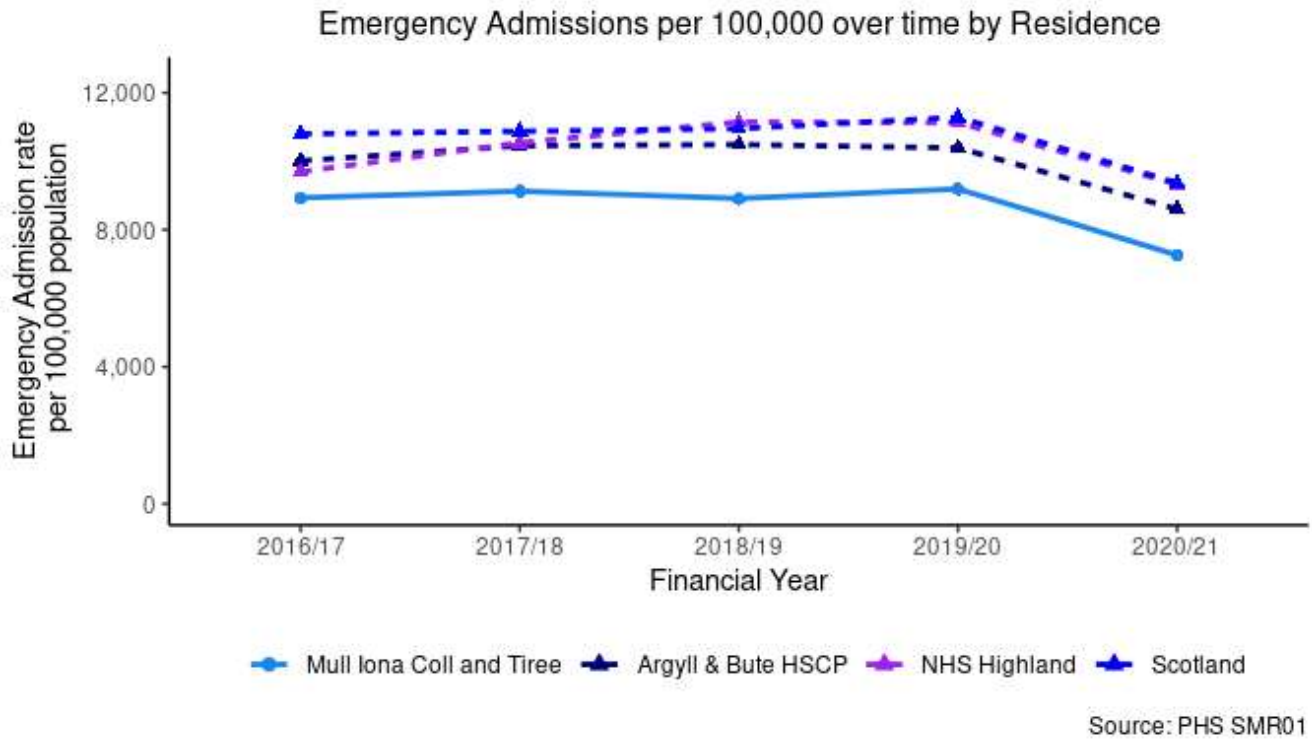


Figure 26: Emergency admissions by geographical area



Unscheduled Acute Bed Days

Figure 27: Unscheduled bed days by age group

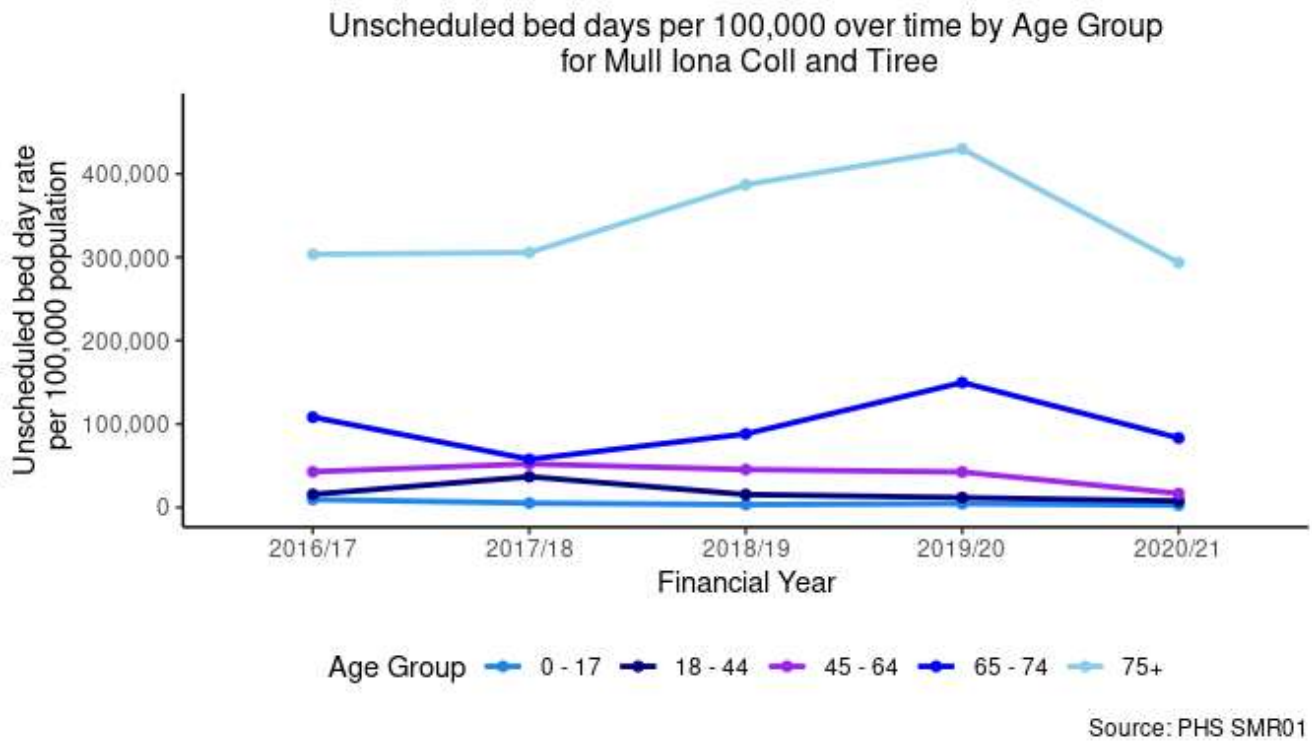
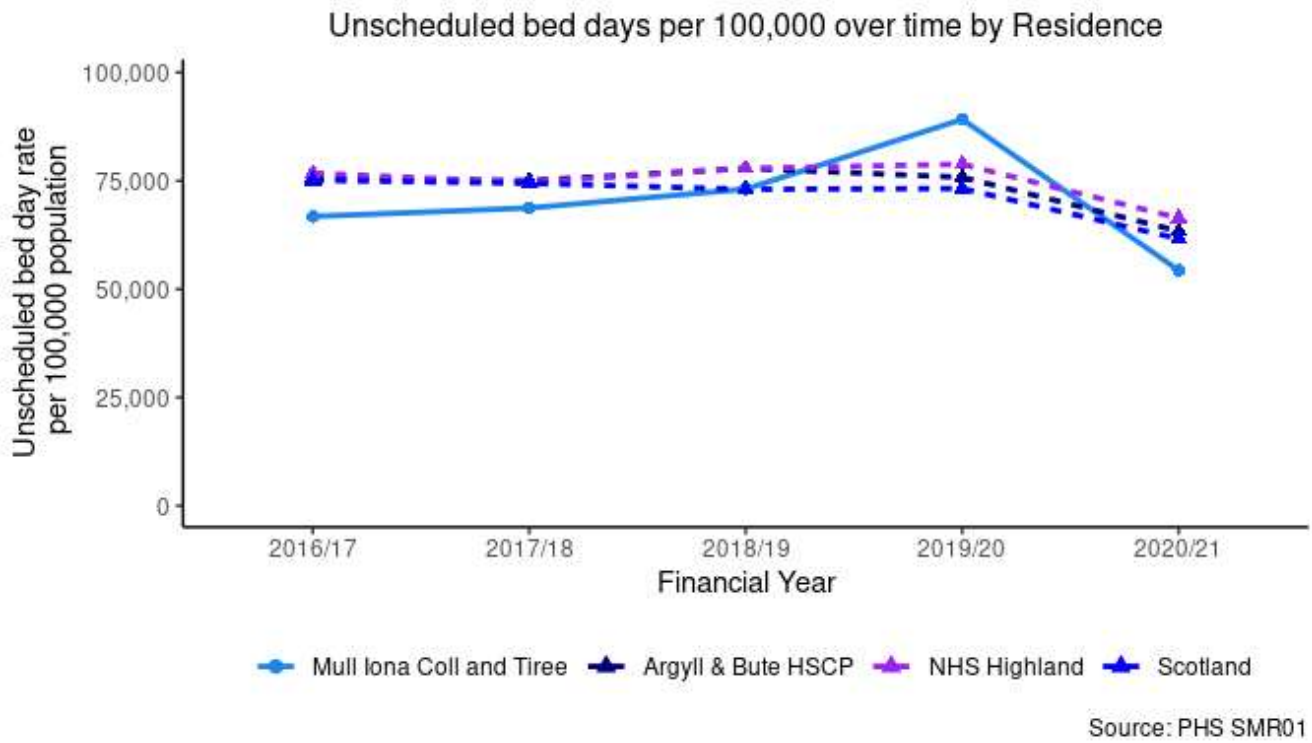


Figure 28: Unscheduled bed days by geographical area



A&E Attendances

Figure 29: A&E attendances by age group

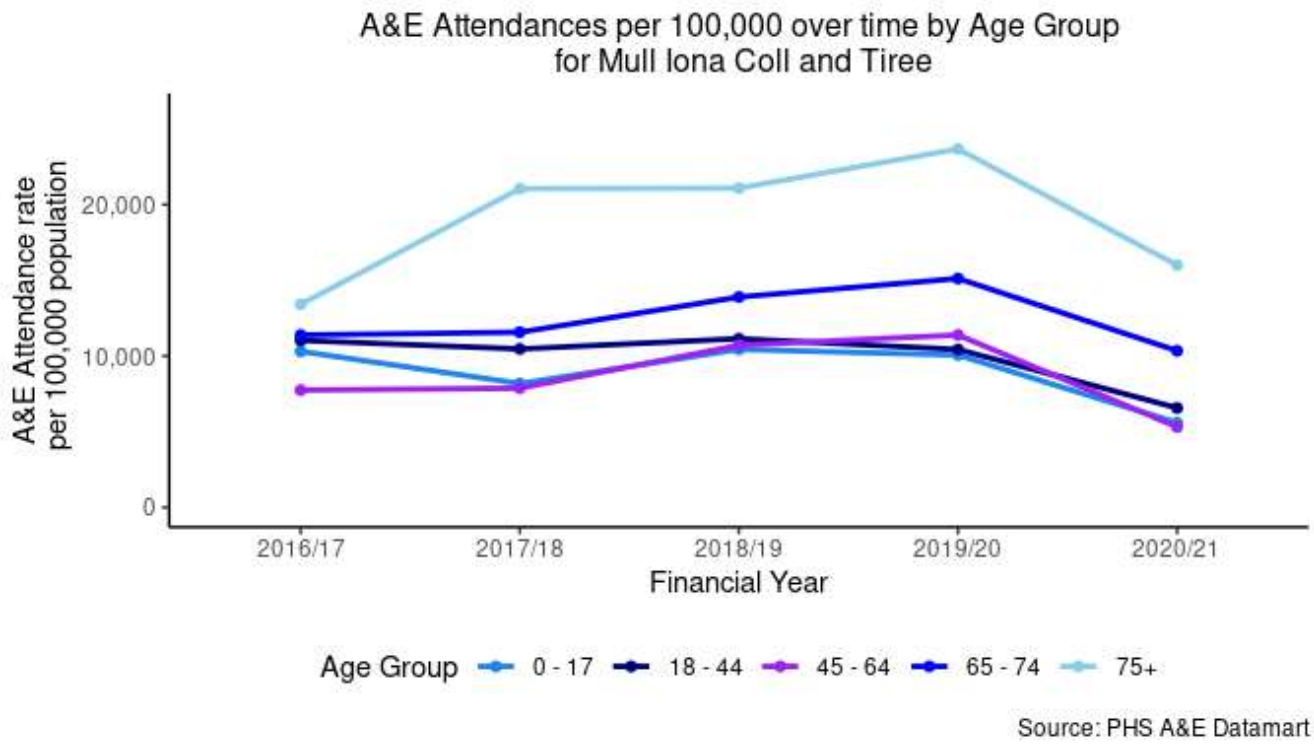
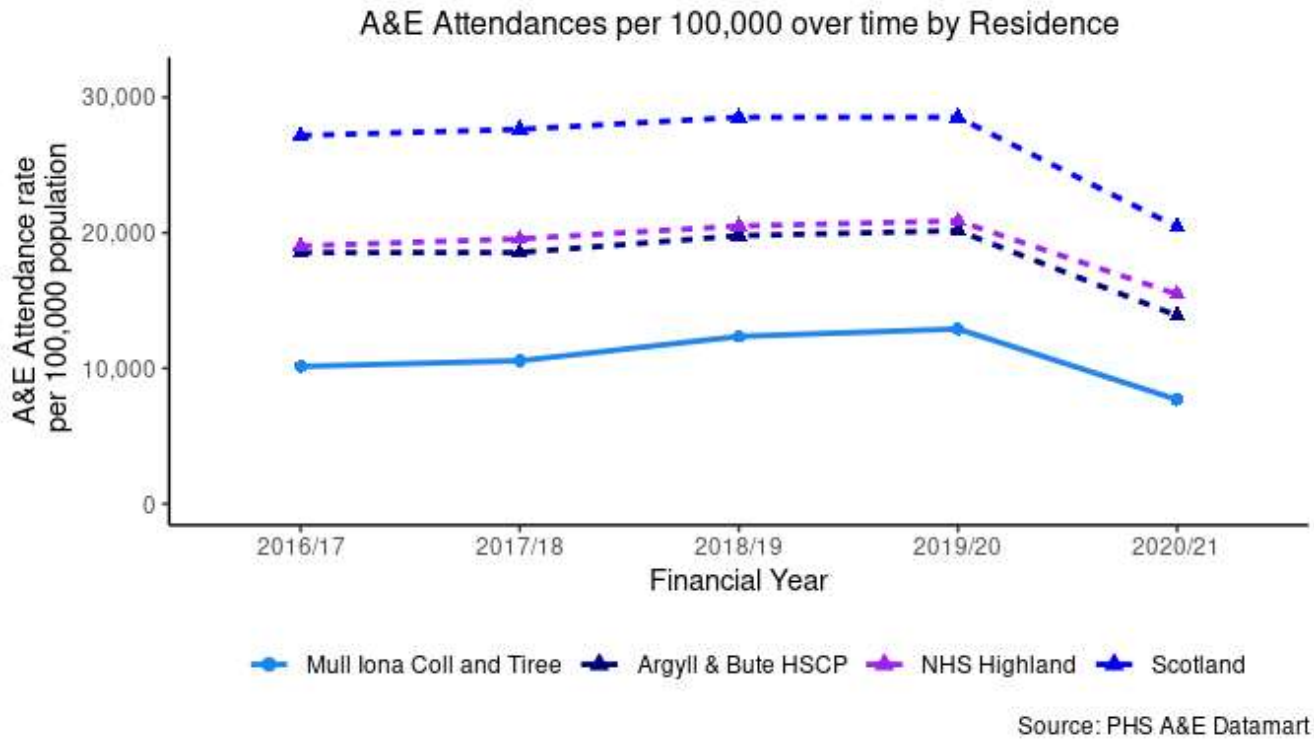


Figure 30: A&E attendances by geographical area



Delayed Discharge Bed Days

Figure 31: Delayed discharge bed days by age group

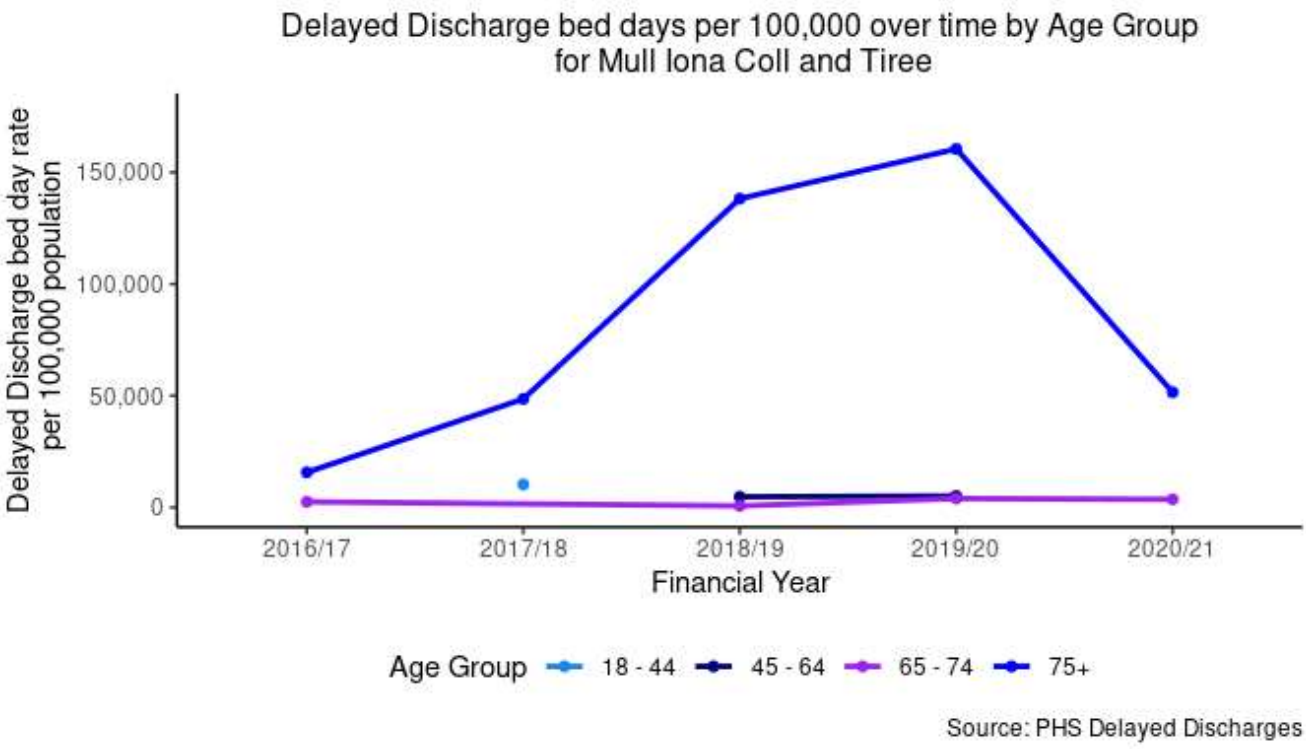
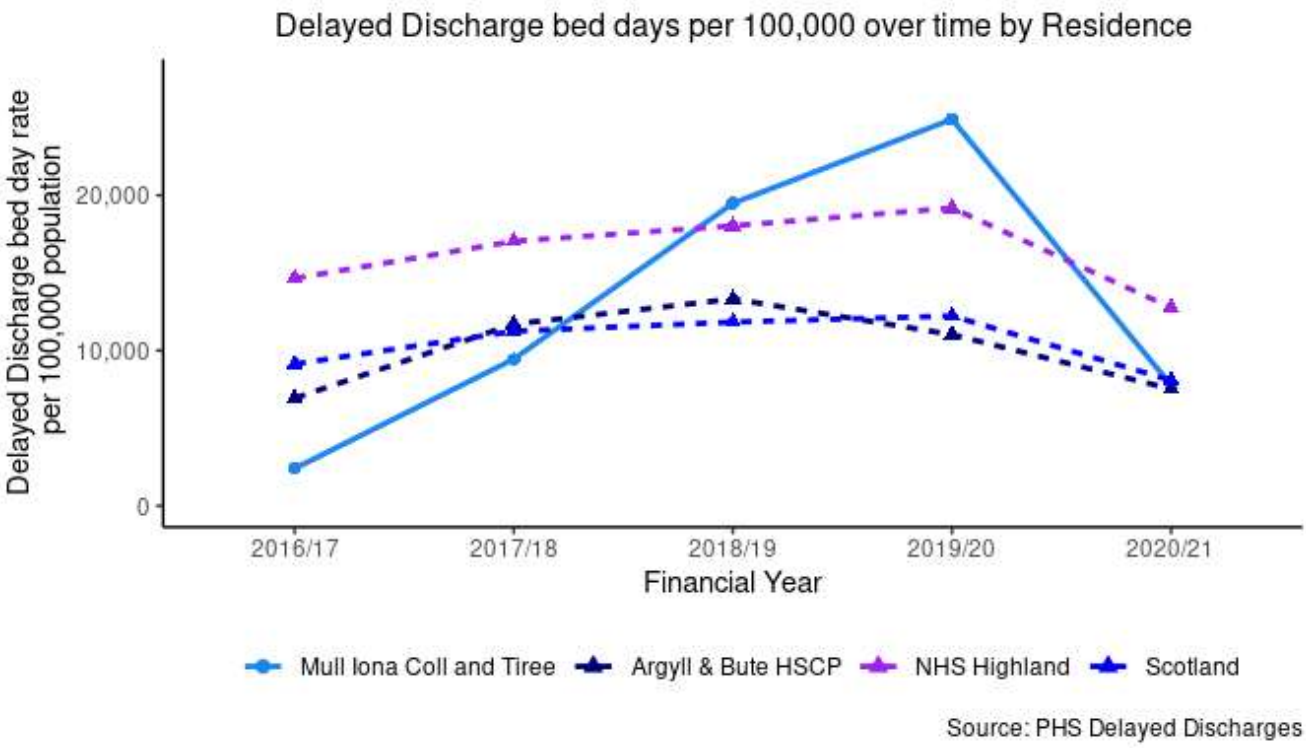
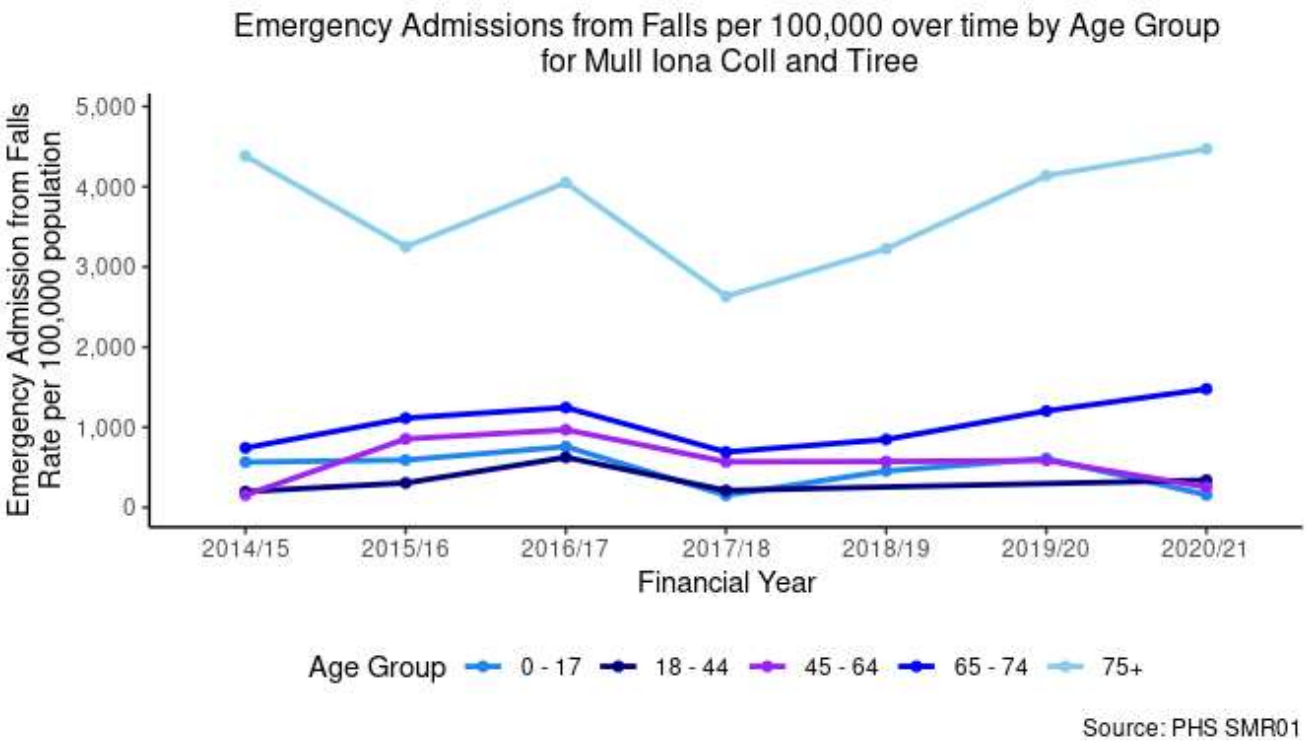


Figure 32: Delayed discharge bed days by geographical area



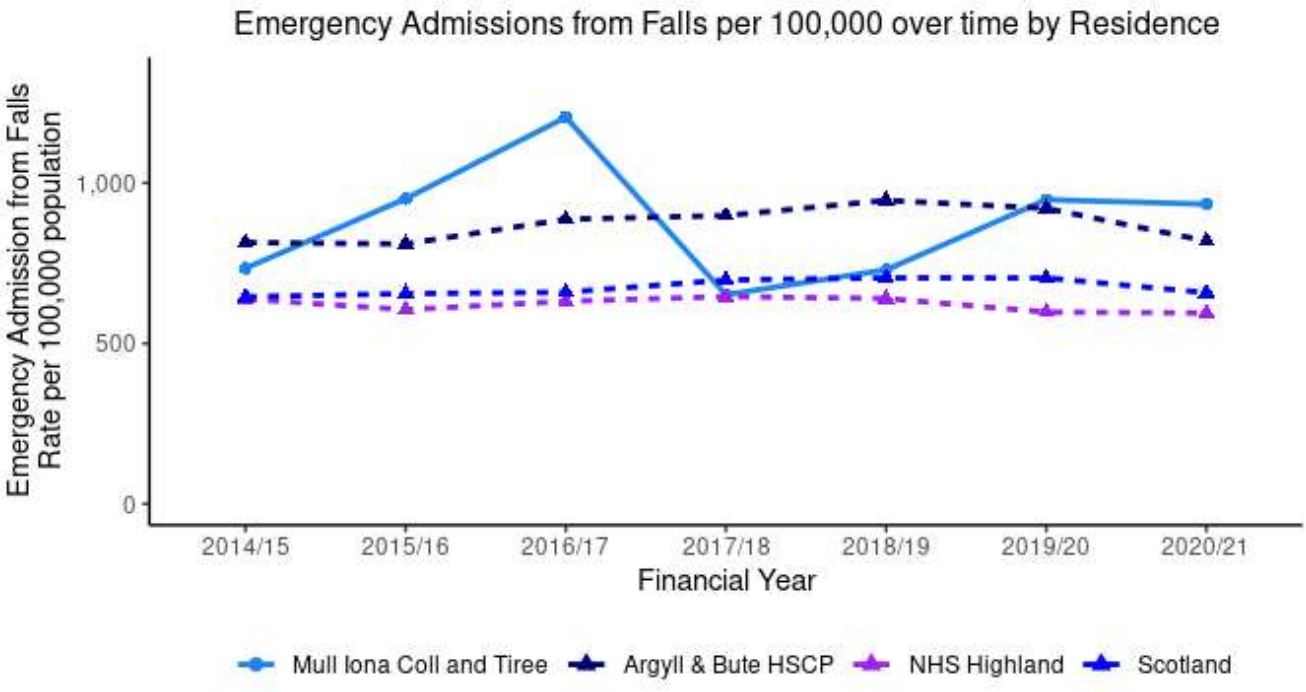
Emergency Admissions from a Fall

Figure 33: Falls by age group



Source: PHS SMR01

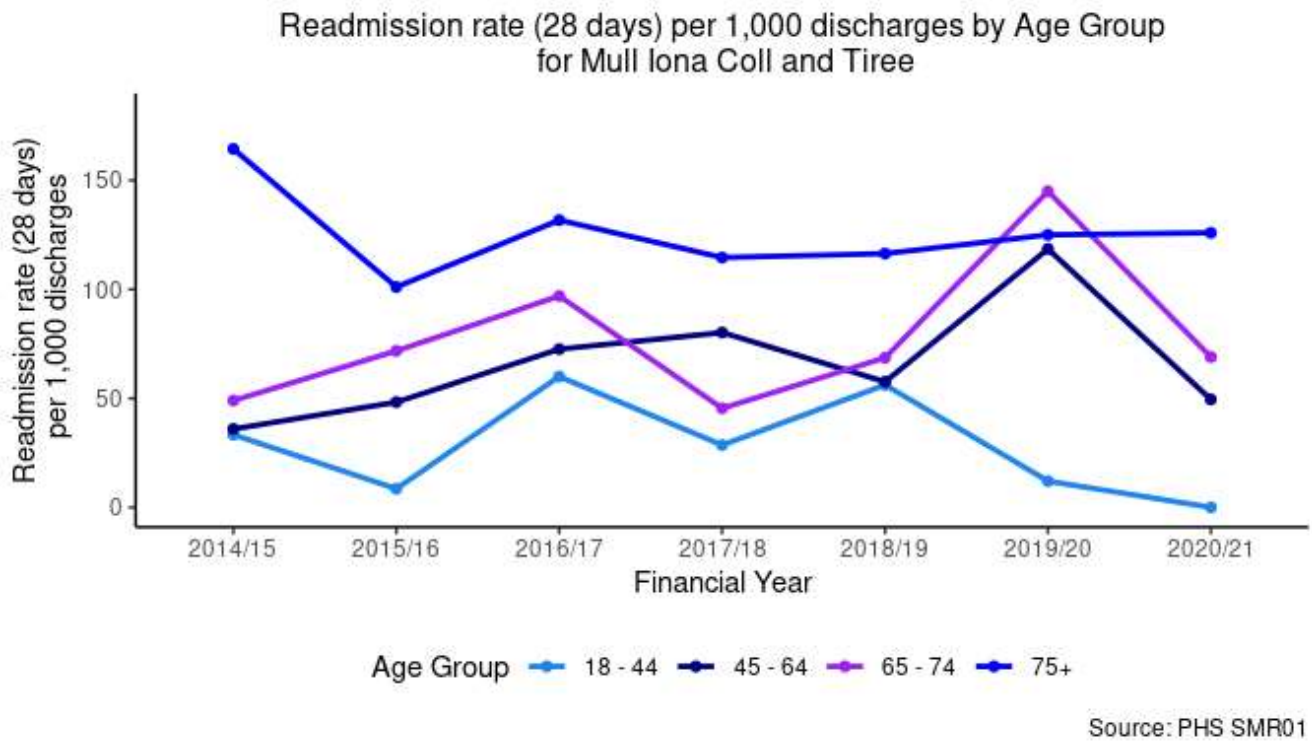
Figure 34: Falls by geographical area



Source: PHS SMR01

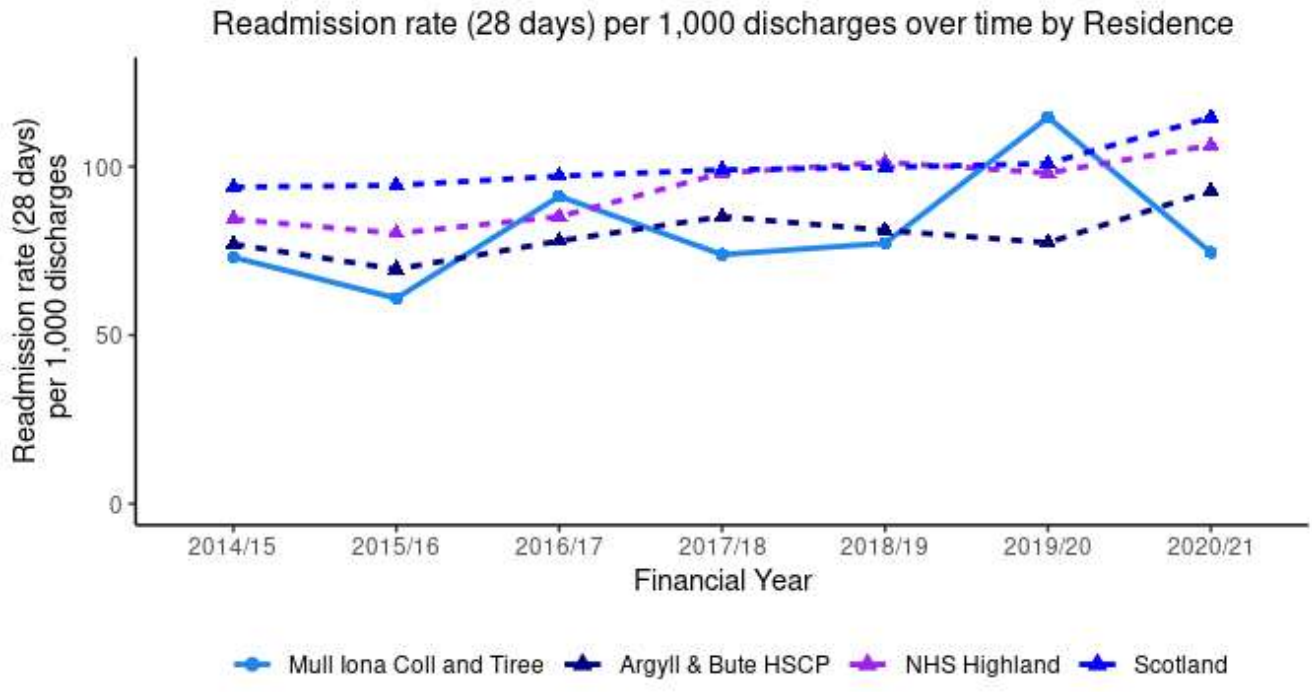
Emergency Readmissions (28 days)

Figure 35: Emergency readmissions by age group



Source: PHS SMR01

Figure 36: Emergency readmissions by geographical area

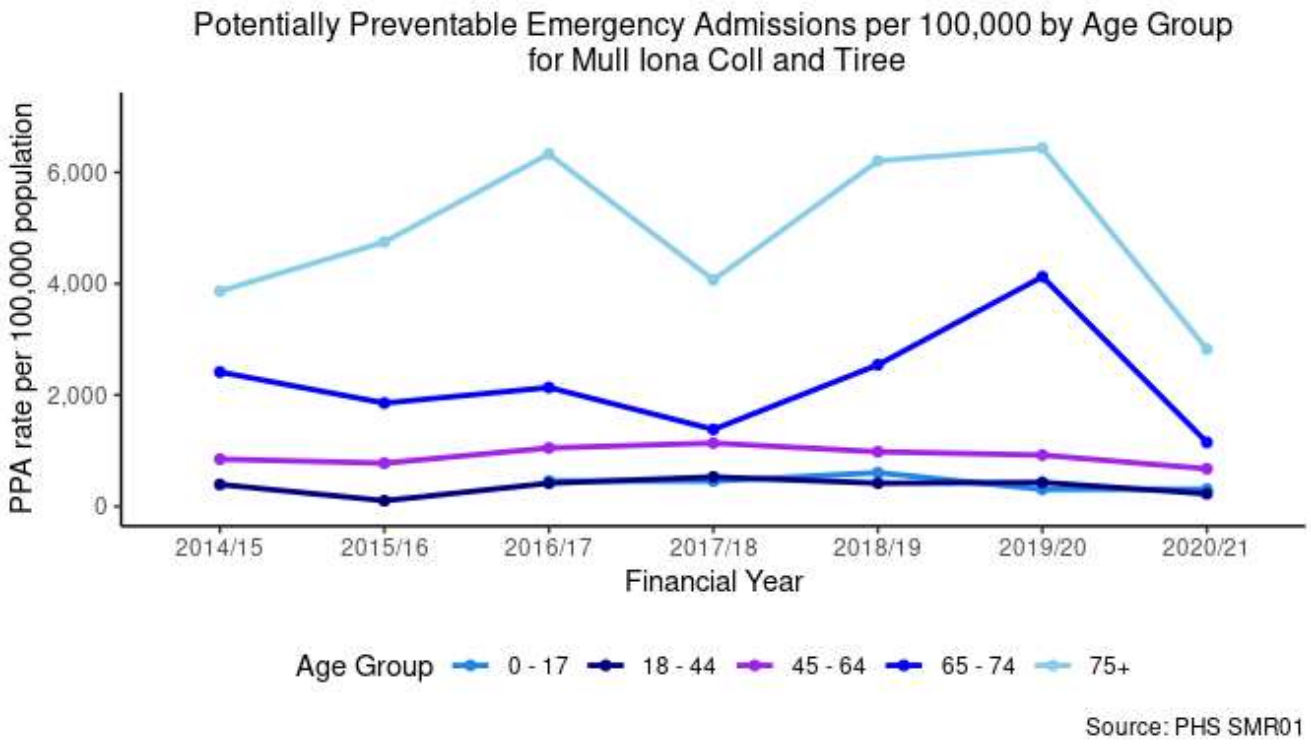


Source: PHS SMR01

Potentially Preventable Admissions (PPAs)

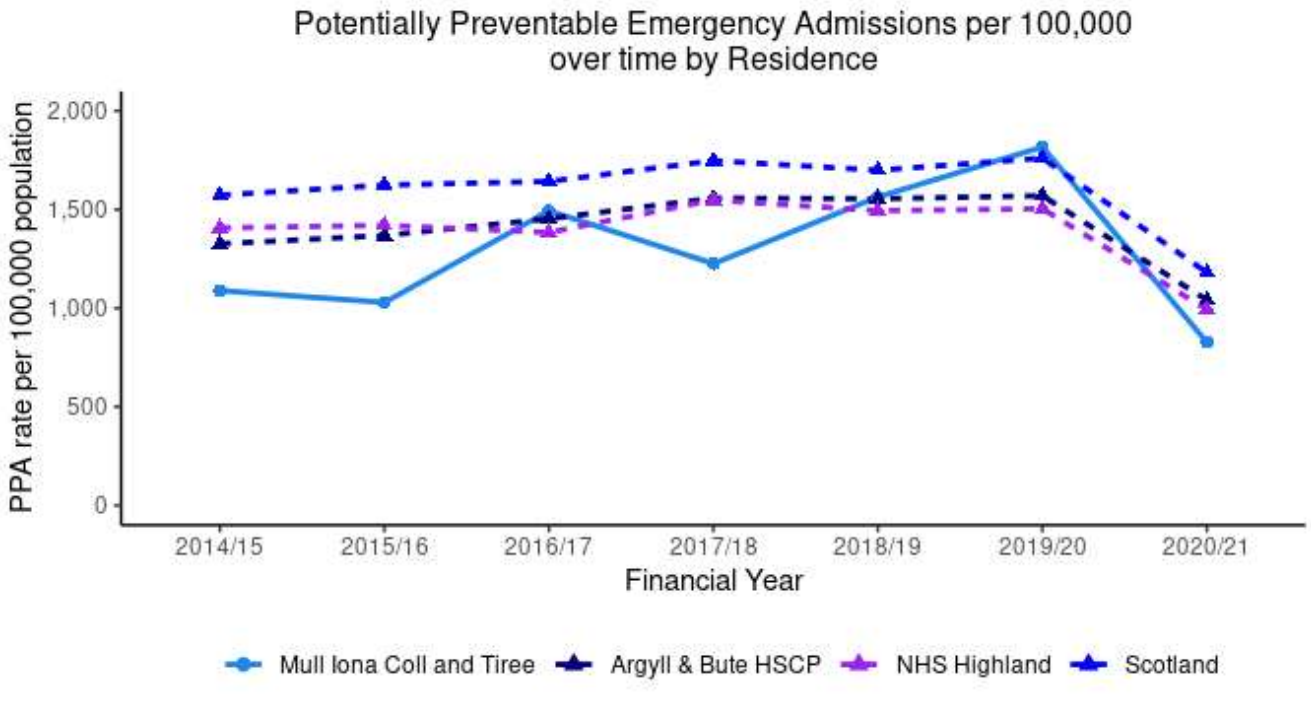
Information on which conditions are counted as PPAs is available in Appendix 3 in the accompanying summary document.

Figure 37: PPAs by age group



Source: PHS SMR01

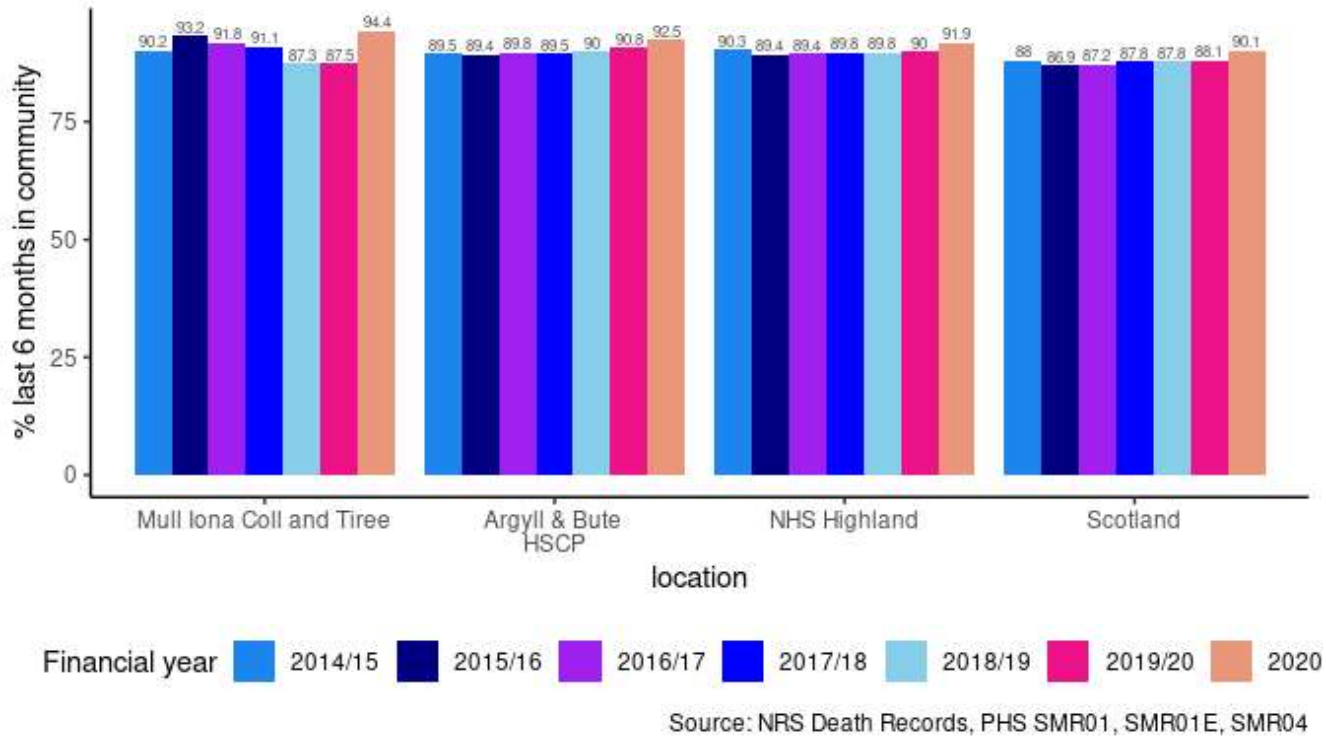
Figure 38: PPAs by geographical area



Source: PHS SMR01

% Last 6 months in a Community Setting

Figure 39: Last 6 months in a community setting by geographical area



Source: NRS Death Records, PHS SMR01, SMR01E, SMR04

Footnotes

1. Population projections are not currently provided by NRS at the locality level. To explore how the population in Mull Iona Coll and Tiree is expected to change in the future, the percent changes in population projection to 2025 for Argyll and Bute by age group and gender were calculated from the NRS Local Authority Population Projections. These percent changes were then applied to the Mull Iona Coll and Tiree 2018 mid-year population estimates (also split by age group and gender) to obtain population projection estimates for Mull Iona Coll and Tiree, based on the projections for the HSCP and the current population structure of the locality.
2. Care Home Data included in the Services Map and Table was sourced from the Care Inspectorate. GP Practice data from October 2021, and Hospital and A&E data was sourced from Public Health Scotland Open Data. Only services that are within the physical boundary of the HSCP or Locality are included in the map and table, so there may be services outside Argyll and Bute which people may use but are not shown.
3. The data used in General Health and Behavioural Factors sections (except for long-term conditions) of this locality profile are taken from ScotPHO. There may be more recent data available for the indicators elsewhere.
4. Data taken from ScotPHO is often reported using the European Age-Sex Standardised Rate per 100,000. This allows for comparisons across different areas to be made. For more information on how these rates are calculated, please refer to www.isdscotland.org/Products-and-Services/GPD-Support/Population/Standard-Populations/
5. Physical long-term conditions data comes from the Source Linkage Files, and the conditions are identified using ICD-9 and ICD-10 codes in the diagnosis fields. Please note that the Source Linkage Files data only contains information on people who have had contact with the NHS through either inpatient admissions, outpatient attendances, daycase attendances, A&E attendances or through prescribed items, the data does not show all service users in Scotland who have been diagnosed with an LTC as not all of these individuals will have used these services. Also note that LTC rates are based on an adjusted population indicator in the Source Linkage Files so that population sizes are closer to the official estimates.
6. The 2020 COVID-19 pandemic will have had an effect on the most recent data available. A dashboard has been created by PHS which show the wider impacts of COVID-19 over many areas. You can access this here: https://scotland.shinyapps.io/phs-covid-wider-impact/

Strategic Performance Monitoring within the Joint Strategic Plan

This report looks to embed a series of key performance metrics and indicators, with each of the services across the HSCP acknowledging 'what they plan to do' and 'how will we know' the identified planned objectives are delivered or that progress towards delivery is being measured.

The sources for 'how will we know' fall broadly into 6 categories of performance metric, from Service Plans or Strategies, KPIs or milestone measures.

An icon will indicate which performance progress measure metric aligns with the 'how we will know' statement within the JSP, and a simple RAG status advises where the performance metric is Red i.e. off Track and unlikely to be delivered, Amber ie in progress and likely to be completed or Green i.e. actioned and or delivered with evidence available.

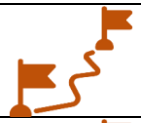
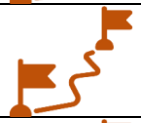
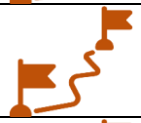
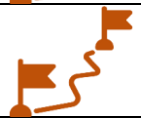
These service performance metrics will be reviewed and updated annually throughout the lifespan of the Joint Strategic Plan.

The HSCP is committed to openness and transparency in respect of performance reporting. Due to service pressures arising from the pandemic during 2020/21, there has been some disruption to reporting as the HSCP focussed on addressing the pandemic and re-mobilisation of services. A revised Integrated Performance Management Framework is been designed and will be rolled out fully in 2022. The HSCP reviews its performance data and uses this to enable it to be responsive to emerging need and service pressures and to continuously improve and inform its strategic planning processes.

Key to Performance Progress Measures

Icon	Description	Further Detail
	Milestone measure	Service will provide evidence of movement towards planned outcome
	Delivery of a Service Plan or Strategy	Service will deliver a specified service plan or strategy
	Key Performance Information or National Statistics	Service specific statutory performance or national statistics will be available
	Report or Review action	Service will deliver report or review action report
	Consultation, Feedback or Engagement action	Service to deliver consultation, feedback or engagement event to inform or monitor service planning objectives
	Service Improvement action	Other service improvement action

Children' Services			
Local Performance			
What we will do	**How will we know**	**Source**	**Timescale**
Early Help and Support- Children and young people's views and opinions inform future development and improvements	We will oversee and align the self-evaluation of services involving Children and Young People under the Children and Young Peoples Services Plan to provide greater uniformity when identifying multiagency and single agency performance measures		
Mental Health & Wellbeing -Children and young people will enjoy good mental health and wellbeing in their schools and community	We will implement the redesign of CAMHS (Child and Adolescent Mental Health Services) to improve access to and the responsiveness of local community based services		
Children and Young People's Voices- Children and young people's views and opinions inform future development and improvements	We will ensure Children and Young People are provided with opportunities to evaluate current services and influence the planning of future services We will ensure that what matters to children and families are at the heart of change We will ensure that services actively listen to families and provide a whole family support service We will ensure young people views are listened to and acted upon Continue to engage with Children and staff on transformation agenda & develop transformation aspirations for the Service		
We will ensure that planning, investment and information is shared widely	Develop programme of change in relation to the Children's Promise Change programme Deliver on the project outcomes for transforming responses to Violence against Women and Girls Report on Performance of outcomes	 	

We will ensure that our workforce is supported and focus will be on building capacity for long term sustainability	Continue to act as a conduit for information and resources on Equally Safe / Train/ National initiatives for managers and staff		
To ensure that the focus for change is aimed at addressing child poverty and within a context of Children's Rights agenda	Deliver on key priorities identified in the Child Poverty Strategy		
We will prevent Children and Young People coming into care through prevention, early intervention and effective alternatives	Continue to deliver on the Children and Young Peoples Service Plan		
We will place Looked After and Accommodated Children (LAAC) closer to their families and communities.	Continue to deliver on the Corporate Parenting Plan		
We will make greater use of the Model of Improvement to ensure long term sustainable changes are embedded in practice	We will oversee and align the self-evaluation of services involving Children and Young People under the Children and Young Peoples Services Plan to provide greater uniformity when identifying multiagency and single agency performance measures Evaluate the outcomes of the 2018-2021 Argyll and Bute Equally Safe Implementation Plan Develop project plan for Transforming Responses to Violence against Women and Girls Project		
National Performance			
Performance Outcomes	**Progress Measure**	**Source**	**Timescale**
Collection and submission of Looked After Children Scotland Statutory Reporting	Looked after children statistics 2020: local authority benchmarking tool - gov.scot (www.gov.scot)		
Latest Educational Outcomes for Looked After Children	Education Outcomes for Looked After Children – 2019/20 - gov.scot (www.gov.scot)		
Latest C&F Services Inspections grades	Datastore (careinspectorate.com)		

SOLACE -CHN8a SOLACE-CHN8b SOLACE-CHN9 SOLACE-CHN19b SOLACE- CHN20b SOLACE-CHN23	The Gross Cost of "Children Looked After" in Residential Based Services per Child per Week The Gross Cost of "Children Looked After" in a Community Setting per Child per Week % of children being looked after in the community School attendance rate (Looked After Children) School exclusion rates (per 1,000 'looked after children') % LAC with more than 1 placement in the last year (Aug-July) Explore the data | Benchmarking (improvementservice.org.uk)		
All children referred to CAMHS will received treatment within 18 weeks	CAMHS are subject to deliver an 18 week wait from referral to treatment for specialist services Child and Adolescent Mental Health Waiting Times - Datasets - Scottish Health and Social Care Open Data (nhs.scot)		
All children will receive a 13-15 month developmental review with a Health Visitor All children will receive a 27-30 month developmental review with a Health Visitor All children will receive a 4-5 year developmental review with a Health Visitor	Early Child Development - 13-15 month review statistics - Datasets - Scottish Health and Social Care Open Data (nhs.scot) Early Child Development - 27-30 Month Review Statistics - Datasets - Scottish Health and Social Care Open Data (nhs.scot) Early Child Development - 4-5 year review statistics - Datasets - Scottish Health and Social Care Open Data (nhs.scot)		
The European Region of the World Health Organization (WHO) recommends that on a national basis at least 95% of children are immunised against diseases preventable by immunisation and targeted for elimination or control. These include diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type b (Hib), measles, mumps and rubella	Childhood immunisation statistics Scotland - Quarter and year ending 30 September 2021 - Childhood immunisation statistics Scotland - Publications - Public Health Scotland		
This release by Public Health Scotland provides a quarterly update of immunisation uptake rates for children in Scotland at 12 months, 24 months, five years and six years of age. Immunisation programmes for children aim to protect the individual child from many serious infectious diseases and prevent the spread of disease in the wider population	Childhood immunisation statistics Scotland - Quarter and year ending 30 September 2021 - Childhood immunisation statistics Scotland - Publications - Public Health Scotland		

This release from Public Health Scotland provides annual statistics on high, low and healthy body mass index (BMI) for Primary 1 school children (those aged around 5 years old), and includes data for school years 2001/02 to 2020/21. Statistics in this release are derived from height and weight measurements collected at health reviews in Primary 1	Primary 1 Body Mass Index (BMI) statistics Scotland - School year 2020 to 2021 - Primary 1 Body Mass Index (BMI) statistics Scotland - Publications - Public Health Scotland		
Encouraging and supporting breastfeeding is an important public health activity. There is good evidence that breastfeeding protects the health of children and mothers. Breastfeeding rates in Scotland are monitored and published annually. The information is collected at Health Visitor reviews of children at around 10 to 14 days (First Visit), 6 to 8 weeks, and 13 to 15 months of age	Infant feeding statistics - Financial year 2020 to 2021 - Infant feeding statistics - Publications - Public Health Scotland		
At least 80% of pregnant women in each SIMD (Scottish Index of Multiple Deprivation) quintile will have booked for antenatal care by the 12th week of gestation	NHS Scotland performance against LDP standards - gov.scot (www.gov.scot)		
Teenage pregnancies	Teenage pregnancies - Year of conception, ending 31 December 2019 - Teenage pregnancies - Publications - Public Health Scotland		
Child Dental health P1 Child Dental Health P7	National dental inspection programme - School year 2019 to 2020 - National dental inspection programme - Publications - Public Health Scotland ScotPHO profiles (shinyapps.io)		
COVID-19 Early Years Resilience and Impact Survey (CEYRIS) report 2021	Search - Public Health Scotland		

Child Poverty			
Local Performance			
What we will do	**How we will know**	**Source**	**Timescale**
Continue to develop the Child Poverty Action Plan and work around tackling the three Drivers of Poverty	Ensure partner agencies contributes actions and activities to the plan and has individual measures to monitor the progress		
Develop a Data Base that allows us to measure changes in the level and nature of child poverty locally and identify groups and communities that require focused interventions from key services	Developed and deliver a database to allow for enhanced local measurement of area of deprivation and permit a greater focus of resources on the most deprived areas		
Look at ways in which the impacts of poverty can be mitigated, seeking to identify gaps and help to create a focus on these	The local Child Poverty Action Group will also use the Child Poverty Assessment Tool to assess the performance of the group and its actions Ensure we are engaging with children, young people and communities and listening to their voices and opinions		
Develop and roll out Poverty Awareness Raising Training to a wide range of staff	Deliver Poverty Awareness training for staff- milestone Ensure that Money Matter training is rolled out to relevant staff and the impact monitored		
National Performance			
Performance Outcomes	**Progress Measure**	**Source**	
Child Poverty in Scotland: health impact and health inequalities	Child Poverty in Scotland: health impact and health inequalities (healthscotland.scot) Child poverty: priority groups - lone-parent families - Publications - Public Health Scotland COVID-19 and lone parents with dependent children - Publications - Public Health Scotland		

Child Protection			
Local Performance			
What we will do	**How we will know**	**Source**	**Timescale**
The Child Protection Committee provides effective leadership and direction in child protection and is accountable for its actions	Committee members understand their role and responsibilities and are supported to exercise these effectively The committee demonstrates its strategic direction and activity through delivery of appropriate business plans The committee undertakes ICR'S & SCR'S as appropriate, and reports and acts on findings		
A learning culture to support continuous improvement is embedded in the CPC and promoted across partner agencies	CPC has robust systems to monitor, measure and to report improvement We review /evaluate child protection service delivery Work with colleagues from APC to identify interface issues that can be jointly addressed The CPC will ensure that there is a comprehensive multi agency child protection training programme in place that is revised on an annual basis to reflect practice priorities The CPC will progress key priorities identified through the practitioner self-evaluation activity and CPC development sessions		
We help our children and young people to keep themselves safe	Child protection in education Scottish Fire & Rescue Service community engagement and keeping children safe		
We effectively identify children at risk share information timeously and act together to protect them from harm	The CPC is alert to the potential that agencies may see an increase in domestic abuse referrals due to COVID-19. All staff across agencies require to have a greater awareness of DA and be confident with appreciative enquiry		

	The quality of our child protection investigations and risk management continues to improve We effectively asses and plan for children at risk We develop our approaches to the child protection case conference model		
Collaboration across Public Protection raises awareness of cross-cutting challenges and opportunities for shared solutions in child protection	We work together to improve the outcomes for children at risk Protection of children is a key aim across public protection planning and delivery particularly in relation to children affected by adult mental health, domestic violence, substance misuse and criminal behaviour		
Children, their carers and their families are supported to be fully involved in child protection decision making processes	The views and experiences of children and their families are systematically recorded and reported to CPC		
Engagement with children, families and communities and raising public awareness	Raising public awareness of child protection need to be a priority of the CPC to ensure that communities are equipped with information that allows them to take action if they are concerned about the safety and wellbeing of a child.		
National Performance			
Performance Outcomes	**Progress Measure**	**Source**	
CHN22 % of child protection re-registrations within 18 months - SOLACE	Benchmarking | Benchmarking (improvementservice.org.uk)		
Collection and submission of Child Protection Statutory Reporting	Child protection statistics 2020: local authority benchmarking tool - gov.scot (www.gov.scot)		
CPC – National Minimum Dataset	Minimum Dataset for Child Protection Committees (celcis.org)		

Violence against women and girls			
Local Performance			
What we will do	**How we will know**	**Source**	**Timescale**
A major area of work in the next 2 years will be the delivery of the Transforming Responses to Violence Against Women and Girls Project that is supported by the DES Fund bid monies. A Programme Board will be established to facilitate this	Feedback from staff, communities and lived experience people. Feedback from the Improvement Service.		
Use of the Domestic Abuse-Informed Practice and Systems: Self-Assessment Tool and Evaluation Framework at the start of the 2 year service transformation project will allow us to assess how services are currently working. The proposed research project by Dr Anni Donaldson will add to this evaluation process and ensure the inclusion of lived experience voices.	Use of the Domestic Abuse-Informed Practice and Systems: Self-Assessment Tool to evaluate service change.		
Develop our Data Base to more readily show the work of the partner agencies and emerging trends in domestic abuse and other gender based violence areas	Research outcomes and conclusions.		
Review the Equally Safe Plan for Argyll and Bute	Outcomes from child protection procedures. Is the roll out of Safe and Together resulting in more children remaining with the non-offending partner? Is this resulting in a reduction in receptions into care?		
Improve communications with lived experience and community groups and put in place a LBTQI Plan	Changes mapped in referrals to key third sector partners.		
Work to improve the services to women and girls with a learning disability who experience, or are at risk of experiencing, domestic abuse. This will focus on training for key teams and individuals and improving pathways	How far the Equally Safe National Standards are being met in Argyll and Bute.		
Work to improve how staff work with men in cases where there are domestic abuse and related child protection issues. This will focus on providing additional training and advice	Provide additional training to improve how staff work with men where there are Domestic Abuse and Child Protection issues.		

National Performance			
Performance Outcomes	**Progress Measure**	**Source**	**Timescale**
Scotland's strategy to eradicate violence against women	Equally Safe: Scotland's strategy to eradicate violence against women - gov.scot (www.gov.scot)		
Gender based violence overview	Overview of gender based violence - Gender based violence overview - Gender based violence - Health topics - Public Health Scotland		
Domestic abuse in Scotland statistics	Domestic abuse in Scotland statistics - gov.scot (www.gov.scot)		

Adult Support & Protection			
Local Performance			
What we will do	**How will we know**	**Source**	**Timescale**
ASP Inspection 2021- Areas for Improvement	Priority areas for improvement All relevant partners should be invited to participate in case conferences and review case conferences. The 'three-point test' is an essential factor in determining if the adult is at risk of harm. The application of the test should be clearly documented during initial inquiry to show decision making rationale. All adults at risk of harm should have a risk assessment, which is comprehensive. There should be a consistent approach to preparing and recording chronologies for all adults at risk of harm who require one.	 	
Deliver an ASP Improvement Plan	Develop & deliver the ASP Improvement Plan		
National Performance			
Performance Outcomes	**Progress Measures**	**Source**	
Adult Support & Protection Improvement Plan	Adult support and protection improvement plan 2019-2022 - gov.scot (www.gov.scot)		
Biennial AP Report	biennial_report_2018-2020_001_master_copy_8.pdf (argyll-bute.gov.uk)		

Community and Criminal Justice			
Local Performance			
What we will do	**How we will know**	**Source**	**Timescale**
Support and monitor the implementation of the Justice Social Work Community Justice Improvement Plan	Develop, implement and Review a local Community Justice Outcome Improvement Plan, in line with the priorities of the Scottish Government national Justice and Community Justice Strategies Continue to work with Community Justice Scotland, in particular, to respond to the publication of the new national Community Justice Strategy and Outcomes Performance and Improvement Framework (expected by June/September 2022 respectively)	 	
Support the Violence Against Women & Girls research project to learn from the experiences of women and improve our responses to men who perpetrate violence against women and girls	Review the learning from the 3 phases of jointly commissioned research report for Violence Against Women & Girls and implement key recommendations Implement and monitor the improvements related to the jointly commissioned Violence Against Women & Girls research		
Produce a local Community Justice Outcome Improvement Plan and related performance framework Embed an approach of continuous improvement in the functioning, delivery and outputs from our Community Justice Partnership	Finalise the review of our local Community Justice Partnership Support and monitor the implementation of the Justice Social Work (Community Justice) Improvement Plan Carry out a validated self-evaluation of our Community Justice Partnership in line with the Care Inspectorate guidance Implement improvements to the Community Justice Partnership identified through the Care Inspectorate validated self-evaluation		

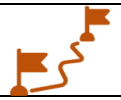
Finalise the Argyll & Bute prison Custody to Community Pathway and develop a monitoring process	Implement the prison Custody to Community pathway, including performance reporting and monitoring		
Strengthen strategic links with other partnerships and develop new strategic links with Third Sector, Children's Services (Youth Justice), Employability, Welfare and other key partnerships	Develop strategic and operational links with Third Sector and Children's Services (Youth Justice) and other key local partnerships		
National Performance			
Performance Outcomes	**Progress Measure**	**Source**	
Community Justice Outcomes Performance Improvement Framework (due to be published Autumn/Winter 2022) and Care Inspectorate Community Justice Guidance	We will monitor progress in line with the national Community Justice Outcomes Performance Improvement Framework (due to be published Autumn/Winter 2022) and Care Inspectorate Community Justice Guidance.		
Community Justice Outcome Activity Across Scotland Annual Report 2020-21 Community Payback Order Summary of Local Authority Annual Reports 2019-20 Community Justice Outcome Activity Annual Report 2019-2020	Reports & Statistics - Community Justice Scotland		

Public Health			
Local Performance			
What will we do	**How will we know**	**Source**	**Timescale**
Develop joint Health Improvement plan between Argyll and Bute and north Highland	Deliver a joint improvement plan between Argyll & Bute and North Highland Develop and deliver performance management processes within wider NHS Highland Public Health Team Deliver department annual report		
Pandemic recovery - Social Mitigation Strategy: child poverty; financial inclusion; children's rights; equalities; mental health improvement and support	Produce report relating to Living Well strategy action plan Produce report relating to Social Mitigation Develop and deliver project specific Project Initiation Documents		
Deliver on the 5-year implementation plan for Living Well strategy: workforce development; self-management; community link working; physical activity; mental wellbeing; suicide prevention; smoking cessation	Deliver on 5-year Implementation Plan for Living Well strategy action plan Build capacity for health improvement: education; Living Well Networks; community planning; locality planning groups; engagement; place-based work		
Respond and deliver national strategy and targets – suicide prevention; smoking cessation; Fairer Scotland	Evaluate LDP/AOP target for smoking cessation		
Alcohol and Drug Strategy actions – reduce drug deaths; recovery orientated support	Evaluate LDP/AOP target for alcohol brief interventions Delver the Alcohol and Drug Partnership annual report		

National Performance			
Performance Outcomes	**Progress Measure**	**Source**	
90% of people referred for help with their drug or alcohol problem will wait no longer than three weeks for treatment that supports their recovery	Drug and Alcohol Treatment Waiting Times - Datasets - Scottish Health and Social Care Open Data (nhs.scot) Dashboard - Alcohol related hospital statistics - Scotland financial year 2020 to 2021 - Alcohol related hospital statistics - Publications - Public Health Scotland		
Scottish Health Survey- Alcohol Consumption	Scottish Health Survey (shinyapps.io)		
National Records for Scotland – Drug Deaths	Drug-related Deaths in Scotland in 2020 | National Records of Scotland (nrscotland.gov.uk)		
COVID-19 Early Years Resilience and Impact Survey (CEYRIS) report 2021	Search - Public Health Scotland		
Covid 19 Immunisations Poverty Substance Use Improving our health and wellbeing	Our areas of work - Public Health Scotland		

Adult Care-Older Adults/Adults and Hospitals			
Local Performance			
What will we do	**How will we know**	**Source**	**Timescale**
Support care at home through a challenging winter, linking unscheduled care elements to limit duplication and make best use of the total resource available	Monitoring the balance of care, ninjured fallers supported at home and reduction in delayed discharges		
Extend the Community Hospitals into the community and provide a greater range of health related skills and services at home	Increasing end of life care at home Reduction in unplanned bed days		
Develop a community assets approach and identify a way in which people can be supported as much as possible within their own community before needing statutory services	Increase in support through community alternatives and prevention services Increase carer support		
Develop a care at home strategy to agree and monitor key developments to build a flexible and sustainable service	Develop and deliver a Care at Home Strategy		
Develop a strategic and inclusive approach to Dementia within Argyll and Bute which sees supporting people with dementia in our communities as essential and part of everyone's role	Develop and deliver a Dementia Strategy		
Developing a meaningful conversation with islands around our health and care services	Develop consultation and feedback with Islands around health and care services		
Develop a robust plan around winter planning, mapping out all elements of service delivery, what the pressures are and how they impact on each other	Develop and deliver a robust plan around winter planning		
Develop a sustainable staffing model at Lorn and the Isles Hospital linking in with the Acute Structure	Develop and deliver Sustainable Staffing Model for Lorn & Isles		
Develop parts of our preventative model through use of Primary Care Link workers	Increase in support through community alternative and prevention services Develop and deliver Preventative Model		

To work in partnership with providers, supporting elements such as recruitment, training to ensure best use of resources	HR – staff vacancy rates/ Commissioned Services- monitoring		
Review the use of Extended Community Care Teams and link them to other community services	Develop and deliver Review of ECCT's		
Complete a building appraisal for internal care homes and develop an overarching care home and housing strategy. This will include the position of intermediate care within Argyll and Bute	Develop and deliver Care Home & Hosing strategy		
National Performance			
Performance Outcomes	**Progress Measure**	**Source**	
Local Delivery Plan Targets	NHS Scotland performance against LDP standards - gov.scot (www.gov.scot)		
Local Government Benchmarking Framework	Benchmarking | Benchmarking (improvementservice.org.uk)		
Care inspectorate Grades	Datastore (careinspectorate.com)		
Social Care Insights Dashboard	https://scotland.shinyapps.io/nhs-social-care/		
Health & Care Experience Survey	Health and Care Experience Survey - gov.scot (www.gov.scot)		
Inpatient Experience Survey	Inpatient Experience Survey - gov.scot (www.gov.scot)		
Eligibility Criteria & Waiting Times	Eligibility criteria and waiting times - gov.scot (www.gov.scot)		
Delayed Discharge	Delayed Discharges in NHSScotland - Datasets - Scottish Health and Social Care Open Data		

Learning Disability Services			
Local Performance			
What will we do	**How will we know**	**Source**	**Timescale**
Review and redesign of LD Day Services across A&B, working in partnership with H&SC staff, care providers, service users, carers and wider communities to develop future models of support	Establish a steering group with responsibility to deliver the Implementation Plan, with representation from partners, including provider organisations - milestone		
Continue to utilise technology and telecare where appropriate to increase independence, whilst ensuring the safety and wellbeing of service users	Establish clear funding priorities and ambitions within the implementation plan (identifying clearly the opportunities and need for savings to be made) – milestone		
Development of short, medium and long term housing strategy to ensure appropriate accommodation models for services users and affordable housing for H&SC staff	Develop and deliver a short, medium and long-term housing strategy- milestone		
Further develop and improve communication and engagement with service users, carers, providers and H&SC to support the co-production of alternative models of care	Identify risks to achieving the strategic outcomes and propose mitigation measures - milestone		
Sustain and further improve on the positive feedback from external regulators regarding the quality of service provision (both internal and external).	Utilise feedback from professionals and those affected by our plans through a Health Impact Assessment and Equality and Socio-Economic Impact Assessment - milestone		
Further development of specialist Core and Cluster housing to support individuals with complex needs and reduce the requirement for individuals to be placed out with the area.	Develop and deliver specialist Core & Cluster Housing for individuals with complex needs - milestone		
Sustain and improve the positive and dynamic relationships with external providers and support services	Develop and deliver Commissioning Plans for all services being delivered		
Increase the uptake of Self Directed Support, through delivery of enhanced training to staff and development of easy read information for service users and/or carers	Deliver enhanced training and easy read information for Self Directed Support- milestone		
Reduce stigma in relation to learning disability and autism through delivery of joint training and/or awareness raising for staff across the HSCP	Establish consultation plans (using the Engagement Specification) with people with learning disabilities and their carers' as part of the process to set our strategic objectives - milestone		

Implementation of the actions set out in the Learning/Intellectual Disability and autism – Recovery and Transformation Plan	Put in place robust monitoring and reporting arrangements to support Learning/ Intellectual Disability and Autism Recovery and Transformation Plan- milestone		
Development of A&B specific Learning Disability and Autism Strategies, in line with the A&B HSCP Engagement Framework	Develop and deliver A&B specific Learning Disability and Autism Strategies		
National Performance			
Performance Outcomes	**Progress Measures**	**Source**	
Scottish Consortium for Learning Disability	The Scottish Commission for People with Learning Disabilities - SCLD		
Learning/Intellectual Disability and autism – Recovery and Transformation Plan	Learning/intellectual disability and autism: transformation plan - gov.scot (www.gov.scot)		
Local Government Benchmarking Framework	Benchmarking | Benchmarking (improvementservice.org.uk)		
Health & Care Experience Survey	Health and Care Experience Survey - gov.scot (www.gov.scot)		
Care inspectorate Grades	Datastore (careinspectorate.com)		

Mental Health Services			
Local Performance			
What we will do	**How will we know**	**Source**	**Timescale**
Continue to support the statutory requirement of Mental Health Officer duties within services	Assess the effectiveness of community supports and strategies for individuals in their homes- milestone		
Refine and implement local Mental Health and Dementia Services Strategies	Deliver reductions in acute hospital admissions and / or use of compulsory measures in terms of detention under Mental Health legislation- milestone Ensure consistency of agreed method of engagement with service users, carers and other relevant representatives- milestone Further develop the review and implementation of Community Mental Health Teams across Argyll and Bute- milestone		
Implement the locality based consultant model of care and work to resolve recruitment difficulties	Deliver locality based consultant care- milestone		
Further monitor the Link Worker initiative for progression through Primary Care Implementation Plan via NHS Highland pilot with a view to applying similar approach to mitigating the impact of problems such as debt and loneliness on mental health	Deliver the Link Worker Initiative via the Primary Care Implementation Plan- milestone		
Continue to explore new technological ways of delivering therapy and support	Evaluate the delivery of therapy and support using technology - milestone		
Review and development of dementia care, including in patient and community services	Ensure that mental health services are delivered in line with the Dementia Strategy- milestone		
Increase crisis interventions in the community to reduce risk and to manage hospital admissions safely, if required	Evaluate and deliver reductions in demand and spend for out of hour's services; Police Scotland and interventions by other emergencies services- milestone Work with Primary Care colleagues to help support the roll out of anticipatory and preventative care strategies associated with the new GP contract- milestone		

National Performance			
Performance Outcomes	**Progress Measures**	**Source**	
90 per cent of patients to commence Psychological Therapy based treatment within 18 weeks of referral.	NHS Scotland performance against LDP standards - gov.scot (www.gov.scot)		
Improved rate of responsiveness to new referrals to Psychological therapies and reduction in waiting list numbers . Optimisation of medical capacity and digital delivery in outpatient settings. Managing increase in demand for PT services (pan Highland including Eating Disorders). Development of service models where no dedicated provision in place e.g. EI in Psychosis (pan Highland), Eating Disorders, Personality Disorder and Forensic (A&B), Primary Care (North Highland). Significant service risks exist due to low baseline staffing and service models.	Scheduled Care (Psychological Therapies) - each service element to deliver to clinical priority CAMHS Psychological therapies waiting times - Quarter ending June 2021 - Psychological therapies waiting times - Publications - Public Health Scotland NHS Scotland performance against LDP standards - gov.scot (www.gov.scot)		
Increase of in hours and establishment of out of hours MH specialist input including home treatment and assessment functions (pan Highland). Likely to require significant investment due to minimal current service and remote and rural delivery costs	MSG 2 – MH Unplanned Admissions Bed Rates Partnership Working in NHSScotland | MSG		
Increase in support hours to supported people reflecting timescales of reopening of building based services and continuation of new/emerging service models.	In-patient Services- increase in available bed days in adult acute pathway ISD Scotland | Mental Health Inpatient Activity | Trend data		

Primary Care			
Local Performance			
What we will do	**How we will know**	**Source**	**Timescale**
Agree an HSCP primary care nurse management structure to oversee the transformed delivery of vaccinations, community treatment and care and some aspects of urgent care within Argyll and Bute	Recruit to primary care nursing posts as agreed in the Primary Care Modernisation Implementation Plan to support community treatment and care and some aspects of urgent care. Continue to develop the Advanced Practitioner role within communities throughout the Argyll and Bute area Increase in activity for physiotherapy and reduced expenditure on pain medication		
Support delivery of vaccine transformation removing the requirement for GP involvement by 1 April 2022. Further develop and continue recruitment to locality based vaccination teams which reflect the additional workload of administering Covid vaccines across practice populations in addition to the extension of existing flu vaccine cohorts	Consider an HSCP model for travel health and travel vaccinations Establish immunisation teams to administer vaccines in all localities and assess recruitment priorities based on the impact on workload of delivering Covid vaccines and the additional flu vaccine cohorts Ensure that locality based vaccination teams and campaign planning are sufficiently robust to deliver Vaccination & Immunisations and Childhood Vaccination in line with their removal from GP practices from 1 April 2022 Identify any ongoing practice involvement in delivery of vaccinations beyond 1 April 2022 under the terms of the transitionary service arrangements (including additional payment arrangements).	 	
Finalise separate business to business contracts with very remote and rural and island GP practices where it has been assessed in an options appraisal exercise that practice delivery is the only option for community treatment and care and some aspects of urgent care	Provide information of what services will not transfer from GP practices as an outcome of the rural options appraisal process. The Scottish Government and SGPC will negotiate a separate arrangement including funding for these practices who will continue to provide services after 1 April 2022 Use and satisfaction with Technology Enabled Care and Home Health monitoring for example psychological therapy,		

	blood pressure monitoring. Treatment related specific outcomes (patient and practitioner)		
Extend a self-referral option for primary care mental health services to additional GP practices. This is being successfully piloted in 1 GP practice in each locality	Establish a baseline of current practice and measure new activity against the baseline, for example spend on antidepressant therapy as opposed to medication, number of referrals to Centre for Mental Health Service (CMHS) for primary care. Finalise a service level agreement with NHS Greater Glasgow and Clyde for the provision of a primary care mental health service for all GP practices in Helensburgh and Lomond		
Mitigate recruitment and remote and rural challenges for Pharmacotherapy by creation of a remote hub model.	Assess the impact on GP practices following the service redesign of Pharmacotherapy using a remote hub model To help address specific recruitment challenges to the pharmacotherapy service a remote hub model is being created in Helensburgh. The hub run by Pharmacy technicians & Assistants with pharmacist oversight will provide a minimum consistent level of service to all practices		
Delivery of a strategy for island health and social care provision specifically for out of hours and urgent care.	Establish a sustainable GP out of hours service for Jura, linking it with Islay and building community resilience		
Agree, finalise and deliver a midwifery model for pertussis delivery across Argyll and Bute.	Deliver the pertussis model for Argyll & Bute		
National Performance			
Performance Outcomes	**Progress Measure**	**Scource**	
GPs to provide 48 hour access or advance booking to an appropriate member of the GP team for at least 90 per cent of patients.	NHS Scotland performance against LDP standards - gov.scot (www.gov.scot)		

We are more informed and empowered when using primary care Our primary care services better contribute to improving population health Our experience of primary care is enhanced Our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care Our primary care infrastructure – physical and digital – is improved Primary care better addresses health inequalities	Primary care: national monitoring and evaluation strategy - gov.scot (www.gov.scot)		

Alcohol & Drug Partnership			
Local Performance			
What we will do	**How we will know**	**Source**	**Timescale**
We aim to continue to work in partnership to deliver the ADP strategy	Develop & deliver the ADP Strategy- milestone		
We will work in partnership to deliver the Medically Assisted Treatment Standards and the objectives of the national mission	Develop & deliver the Medically Assisted Treatment Standards- milestone		
We will work with partners to deliver a Cowal hub that offers a one stop shop to support services including, advocacy, GP practice staff, drug and alcohol treatment services, etc. If successful we plan to develop hubs in other localities	Develop & deliver the Cowal Hub- milestone		
We will assess the needs analysis and move forward with a revised approach to support for children and young people affected by their own or another's substance use	Develop & deliver a plan to support children and young people affected by their own or another's substance use - milestone		
National Performance			
Performance Outcomes	**Progress Measures**	**Source**	
90% of people referred for help with their drug or alcohol problem will wait no longer than three weeks for treatment that supports their recovery	Drug and Alcohol Treatment Waiting Times - Datasets - Scottish Health and Social Care Open Data (nhs.scot) Dashboard - Alcohol related hospital statistics - Scotland financial year 2020 to 2021 - Alcohol related hospital statistics - Publications - Public Health Scotland		
Scottish Health Survey- Alcohol Consumption	Scottish Health Survey (shinyapps.io)		
National Records for Scotland – Drug Deaths	Drug-related Deaths in Scotland in 2020 | National Records of Scotland (nrscotland.gov.uk)		

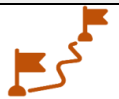
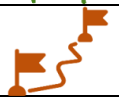
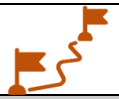
Carers			
Local Performance			
What we will do	**How we will know**	**Source**	**Timescale**
All Carers are identified at the earliest opportunity and offered support to assist them in their caring role Young Carers are supported with their Caring roles and enabled to be children and young people first Mental and physical health of Carers is promoted by ensuring that they can access or be signposted to appropriate advice, support and services to enable them to enjoy a life outside their caring role Carers have access to information and advice about their rights and entitlements to ensure they are free from disadvantage or discrimination in relation to their caring role People who provide care are supported to look after their own health and wellbeing which includes reducing any negative impact of their caring role on their own health and wellbeing	Ensure all carers identified are offered support to assist them in their caring role- milestone Ensure all young carers identified are offered support to assist them in their caring role- milestone Ensure carers are sign posted to appropriate support- milestone Ensure carers have access to information and advice they need- milestone Ensure that people providing care are supported to look after themselves reducing any negative impact on their caring role- milestone		
National Performance			
Performance Outcomes	**Progress Measure**	**Source**	
Health and Care Experience Survey	Health and Care Experience Survey - gov.scot (www.gov.scot) NI-8 % of carers who feel supported to continue in their caring role People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and well-being.		
Carers Census, Scotland	Carers Census, Scotland, 2019-20 and 2020-21 - gov.scot (www.gov.scot)		

Prevention Programme			
Local Performance			
What will we do	**How we will know**	**Source**	**Timescale**
In preparation of the proposed National Care Service and the plan to increase prevention and early intervention the Transformation Board has agreed that we elevate this work stream to consider all aspects of prevention across our health and social care services.	Prioritising workforce education on health behaviour change - milestone Consultation and engagement with public and staff to evaluate readiness for prevention and how the community wish to engage with this approach- milestone Collate ideas to increase prevention and early intervention in preparation for National Care Service roll out- milestone	  	
National Performance			
Performance Outcomes	**Progress Measures**	**Source**	
National Care Service Review	A National Care Service for Scotland - Scottish Government - Citizen Space (consult.gov.scot)		
A&B Joint Strategic Needs Assessment	Joint Strategic Needs Assessment (JSNA) | Healthy Argyll and Bute		

Technology Enabled Care			
Local Performance			
Performance Outcomes (What we will do)	**Progress Measure**	**Source**	**Timescale**
Over the next three years we intend to increase the use of digital services and further develop TEC services within Community Teams to ensure it is a core service. We will also further develop 'Attend Anywhere' clinics in Dermatology, Respiratory and Gynaecology pressure specialities significantly reducing travel for appointments.	Monitor and review the number of clients with a digital solution in place Develop and delivery of 'Attend Anywhere' clinics		
The use of home health monitoring will be expanded to help for example titrate medication to clients, freeing up staffs time to offer more direct patient care.	Continue to measure how many priority referrals are responded to within the appropriate timescale		
We will also complete our new Argyll and Bute TEC strategy, which will include the shift from Analogue to Digital technology.	Deliver the Argyll and Bute TEC strategy - milestone		
National Performance			
Performance Outcomes	**Progress Measure**	**Source**	
Social Care Information Dashboard – Community Alarms/Telecare	https://scotland.shinyapps.io/nhs-social-care/		
Technology Enabled Care – Benchmarking Network	Technology Enabled Care (TEC) | TEC Scotland		

Corporate Services			
Local Performance			
What we will do	**How we will know**	**Source**	**Timescale**
Continue with co-location of health and social care corporate staff to work together in the same locations and in the same teams both physically & virtually	Use co-location of health, social care and corporate staff to continue to reduced number of buildings and estate- milestone		
Integrate health and social work administration and implement digital technology- progress digital health and care record	Improve and deliver productivity benchmark targets- milestone		
Facilitate and support agile and mobile working for community based staff across the health and social car partnership including the independent sector	Significant cost reduction in corporate services of between 10-20% (To be confirmed)- milestone		
Progressing the plan to implement a single health, social care, and education catering service in Argyll and Bute	Implement a single health , social care and education catering service- milestone		
Continue to improve the cost and use of Health and Social care business fleet to improve service to users and reduce cost and CO2 footprint achieve 2025 target	Ensure more efficient fleet services a reduce CO2 footprint and costs for 2025- milestone		
National Performance			
Performance Outcomes	**Progress Measures**	**Source**	
Ensure that staff want to work in Argyll & Bute HSCP	NI 10- Percentage of staff who say they would recommend their workplace as a good place to work		
We will deliver our 6 outcomes and make Argyll and Bute a place people choose to Live, Learn, Work and Do Business	1. Our Economy is diverse and thriving 2. We have an infrastructure that supports sustainable growth 3. Education skills and training maximise opportunities for all 4. Children and young people have the best possible start 5. People live active, healthier and independent lives 6. People will live in safer and stronger communities corporate_plan_2018_181119_v2.pdf (argyll-bute.gov.uk)		

NHS Highland Remobilisation Plan 2021 - 2022	Remobilisation June 2021.pdf (scot.nhs.uk)		

Allied Health Professionals			
Local Performance			
Performance Outcomes (What we will do)	**Progress Measure**	**Source**	**Timescale**
Increase capacity of AHP professions to deliver preventative and early intervention, progress to prehab and preablement as well as rehab and reablement	Ensure appropriate staffing levels within all AHP Services- milestone		
	Deliver on NHS Highland Remobilisation Plan 20221-22		
	Embed OT and Physiotherapy into primary care as part of primary care modernisation- milestone		
	Increased our rehabilitation skills in all areas to support major trauma, long-term conditions and neurological conditions and diseases- milestone		
	Recruitment of a Housing OT to support assessments for adaptations to individual housing- milestone		
National Performance			
Performance Outcomes	**Progress Measure**	**Source**	
To maximise opportunities associated with delivering high quality care whilst maintaining people's independence, moving from institution centred and service led care delivery to community based, decentralised care delivery	NI 12 Rate of Emergency Admissions per 100,000 NI14 Readmissions to hospital within 28 days per 100,000 NI 15 proportion of last 6 months of life spent at home or in a community setting MSG 3.1- Number of A&E attendances Remobilisation June 2021.pdf (scot.nhs.uk)		
Community Health Activity Dataset (CHAD)	Health and Social Care | Community Health Activity Data | Health Topics | ISD Scotland		

Digital Health & Care Strategy			
Local Performance			
Performance Outcomes (What we will do)	**Progress Measure**	**Source**	**Timescale**
The HSCP will progress its digital modernisation by focusing on the 6 priority areas	1. Continue with co-location of health and social care corporate staff to work together in the same locations and in the same teams both physically & virtually 2. Integrate health and social work administration and implement digital technology- progress digital health and care record 3. Facilitate and support agile and mobile working for community based staff across the health and social car partnership including the independent sector 4. Modernise and automate our admin processes and free up staff resource to support front line services 5. Harness the opportunities of “big data2 and the internet of things to improve services to users, patient and clients and reduce burden of work on staff 6. Provide enhanced training and support to develop a digitally skilled workforce across health and care enhancing digital literacy		
National Performance			
Performance Outcomes	**Progress Measure**	**Source**	
Scottish Government- Digital First Improvement Project	Digital Digital First Improvement Project. - Digital (blogs.gov.scot)		
Argyll & Bute HSCP Digital Modernisation Strategy 2022-2025	Health and Social Care Partnership (argyll-bute.gov.uk)		
Argyll & Bute ICT AND Digital Strategy 2021-2024	ICT and Digital Strategy 2021 - 2024 (argyll-bute.gov.uk)		

Right Care Right Time			
Local Performance			
Performance Outcomes (What we will do)	**Progress Measure**	**Source**	**Timescale**
Enhancing community services to keep people at home, carry out increased assessment at home rather than in hospital and to increase reablement and independence to reduce dependency on care at home.	**Assessment** • Increase in assessments carried out at home rather than hospital. • Evidence of a reduction in the number of people waiting for an assessment. • Evidence of a reduction in the length of time people are waiting for an assessment **Care at Home** • Numbers of people waiting for assessment of care • Numbers of people waiting for care • Unmet hours reduced **TEC/Equipment** • Increase in the use of community equipment and technology to enable care, or other digital resources to support care provision. • Evidence of resource to support the use of technology and digital resource		
Minimising delay when in hospital with robust community pull back home, a streamlined and clear process for planning discharge and aiming to reduce the need for admission for some procedures, this can be known as Interface Care	**Delayed Discharges** • Number of people delayed in their discharge from hospital. • Significant reductions in delayed discharge and occupied bed days • Number of people moved to interim care, number of people moved on from interim care and average length of stay		
National Performance			
Performance Outcomes	**Progress Measure**	**Source**	

Eligibility Criteria & Waiting Times	Eligibility criteria and waiting times - gov.scot (www.gov.scot)		
Delayed Discharge	Delayed Discharges in NHSScotland - Datasets - Scottish Health and Social Care Open Data		
Social Care Information Dashboard – Community Alarms/Telecare	https://scotland.shinyapps.io/nhs-social-care/		
Technology Enabled Care – Benchmarking Network	Technology Enabled Care (TEC) | TEC Scotland		

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Date of Meeting: **25 May 2022**

Title of Report: **Provisional Year End Finance Position 2021-22**

Presented by: **James Gow, Head of Finance and Transformation**

The Integration Joint Board is asked to:

- Note that the provisional financial outturn for 2021/22 is an underspend of £682k against available resources.
- Note that the full debt balance of £2.8m owed to Argyll & Bute Council has been settled during the year.
- Note that the IJB is expecting to carry forward £21.2m as earmarked reserves.
- Note that the figures contained within this report are provisional and subject to external audit.
- Request the Finance & Policy Committee to consider a reduced frequency of meetings now the IJB no longer holds a debt liability due to the council.

1. EXECUTIVE SUMMARY

1.1 This report provides a provisional year-end financial position for 2021/22. Members of the IJB should be aware that the figures contained within this report are being finalised at the time of writing and are subject to independent external audit review.

1.2 The revenue position for the year is a favourable one. The HSCP expects to be reporting that it operated within the resources available to it and that all of its outstanding debt to Argyll and Bute Council was repaid. Additionally, the HSCP expects to be reporting a small surplus, totalling £682k for the year, which it intends to carry forward for use in future years to facilitate service transformation.

1.3 In respect of reserve balances, the HSCP will also be reporting a significant increase in its earmarked reserves, this is due to additional funding announced late in the year and some slippage on projects due to the pandemic. These reserves total £21.2m are being carried forward for specific purposes.

1.4 Overall the financial position of the HSCP significantly improved during 2021/22, building on the positive outturn the year before. The HSCP no longer has any liability for debt and can now establish its own general reserves. It is suggested that this improved position provides a basis for the Finance & Policy Committee to re-consider the frequency of its meetings which are currently held on a monthly basis.

2. INTRODUCTION

2.1 This report provides a provisional financial outturn for the 2021/22 financial year. The figures presented are subject to further review and external audit. The unaudited accounts are scheduled to be published by the end of June and the final audited accounts by the end of November 2022. This report also summarises the final position in respect of the savings programme for the year and provides an analysis of the reserves the HSCP is carrying forward into future years.

3. DETAIL OF REPORT

3.1 Year to 31 March 2022 - Provisional

3.1.1 A small underspend totalling £682k against the budget of £307m is reported for the year. The figures below are prepared on a full accruals basis and Appendix 1 provides further analysis:

Service	Actual £000	Budget £000	Variance £000	% Variance
COUNCIL SERVICES TOTAL	75,150	75,832	682	0.9%
HEALTH SERVICES TOTAL	231,575	231,575	-	0%
GRAND TOTAL	**306,725**	**307,407**	**682**	**0.2%**

3.1.2 In respect of Social Work budgets, the reported position is an underspend against allocated resources of £682k. This is better again than forecast as non-recurring underspends continued through to the end of the year and new funding was used to support cost pressures.

3.1.3 Appendix 1 provides the service analysis in the usual format, however, there are two main service variances of note. Firstly Older people services reported a £1.3m underspend due to reduced demand and higher fee income. Conversely, the Learning Disability Budget was overspent by £1.2m due to higher levels of demand and slippage with savings.

3.1.4 The key issue in respect of Social Work services relates to budget adjustments which have been made in respect of the repayment of the outstanding debt to Argyll and Bute Council. This is analysed in section 3.2.3.

3.1.5 For Health Service budgets, the revenue position is that spend is in line with the budget allocated. There are a number of offsetting variances against budget and an analysis of these is provided in appendix 1. The main area of overspending relates to some additional year end charges from NHS Greater Glasgow and Clyde, particularly relating to oncology drugs. Non-recurring savings relating to

vacancies have offset slippage on the Health Service savings programme, this has not been funded. The position also needs to be considered in the context of the earmarked reserves which have been carried forward into 2022/23, further information on this is provided below and in appendix 2.

3.2 Consolidated Position

3.2.1 Revenue Position

The consolidated revenue position for 2022/23 is summarised below:

	£'000
Allocated Resources	307,407
Total Expenditure	306,725
Surplus for year	**682**

Overall, the HSCP is therefore reporting that it spent slightly less than the resources available to it during the year. It is anticipated that the underspend will be carried forward. It is intended this will be used to support spend on Transformation projects, notably Older Adults programmes and the Learning Disability Day Services restructuring costs.

3.2.2 Reserves

At the year end, the IJB is able to carry forward resources which have been allocated to it and not spent within the year. The table below summarises the reserves brought forward into 2021/22 and those that are being carried forward into 2022/23. A large proportion of the new reserves allocated during the year were confirmed late in the year, as reported at the time, and could not be spent by 31 March. It is anticipated that HSCPs in general will not have spent large proportions of the in-year allocated funding and reserves are expected to have therefore increased. Each reserve has an allocated service manager with responsibility for the associated work. Appendix 2 provides a full listing of the year end reserves and a brief description of the purpose for which they are currently earmarked. The IJB will be formally asked to approve these as part of the process of finalising the year end accounts and a full disclosure of these will be published in the Annual Accounts.

	Health (£'000)	Social Work (£'000)	Total (£'000)
Opening Reserves	4,197	2,389	6,586
Closing Reserves as at 31 March 2022	**19,049**	**2,201**	**21,250**

Of the closing reserves figure, £682k relates to the underspend within Social Work budgets, this is being carried forward to fund transformation projects in the new year and a request to that effect has been made to Argyll & Bute Council.

3.2.3 Debt

Members will be aware that the HSCP has owed a substantial balance to Argyll & Bute Council. This debt related to the Council having to fund overspending by the HSCP in previous years. A significant repayment was made during 2020/21

and the remaining balance has been cleared during 2021/22. This has been possible due to non-recurring underspends against budget and as a result of the Scottish Government providing funding for slippage against the savings programme. The table below summarises the debt repayment:

Debt due to Argyll & Bute Council	**£'000**
Opening balance owed	2,759
Budgeted repayment	(200)
Additional Repayment – funded from forecast underspends and funding for savings slippage	(1,856)
Additional Year End Repayment – funded from additional year end underspend	(703)
Closing Balance	**0**

The HSCP sought to manage its year end position carefully in the context of increased in-year funding and non-recurring savings. The settlement of the debt in full now enables the HSCP to establish its own general reserves going forward. It also means that the HSCP has no longer term balance sheet liabilities to report.

3.2.4 Savings Delivery

Another key aspect of financial performance for the year is the delivery of the savings programme. A report on this was considered by the Finance & Policy Committee at its meeting in April 2022, this report provides further detail and is available on request. The table below provides a summary of performance against the savings target for the year, this is in line with recent forecasts and the figures reported below are incorporated within service budgets:

2021/22 Savings	**Target £' 000**	**Achievement £' 000**	**Shortfall £' 000**	**%**	**Carry Forward**
Fully Achieved	5,059	5,059	0	100%	
Carried Forward	2,572	641	1,931	25%	1,931
Cancelled / Reduced	1,704	108	1,596	6%	126
Additional Non-Recurring		725	-725		
NHS Underspend to balance		1,703	-1,703		
Total	**9,335**	**8,236**	**1,099**	**88%**	**2,057**

The delivery of savings has been interrupted by covid which has contributed to the delayed some projects. Overall, £5.8m of recurring savings were delivered during the year, service managers have worked hard to achieve this level of savings which has in turn contributed to the overall financial position of the HSCP. Appendices 3a, b and c provide a detailed analysis on a project by project basis. Carried forward projects will be added to the new savings target for 2022/23 and will be monitored and reported upon in line with established processes.

4. RELEVANT DATA AND INDICATORS

4.1 Information is derived from the financial systems of Argyll and Bute Council and NHS Highland.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

5.1 The improved financial position, increased reserves and the repayment of the debt provides the HSCP with increased financial flexibility to enable it to progress its strategic priorities and transformation agenda.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact – the reported position is a favourable one and indicates that the HSCP is in a much improved financial position at the end of 2021/22. This has favourable implications for 2022/23 and beyond as anticipated budgets for debt repayment are no longer required. It is also suggested in this report that the Finance & Policy Committee may wish to reduce the frequency of their meetings as the IJB no longer owes debt to Argyll & Bute Council and the current level of enhanced oversight of the financial position may not be required.

6.2 Staff Governance – None directly from this report but there is a strong link between HR management and delivering a balanced financial position. Difficulties experienced in recruiting to posts has contributed to the favourable position.

6.3 Clinical Governance – None.

7. PROFESSIONAL ADVISORY

7.1 Professional Leads are engaged in financial planning and reporting.

8. EQUALITY AND DIVERSITY IMPLICATIONS

8.1 None directly from this report.

9. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

9.1 None directly from this report.

10. RISK ASSESSMENT

10.1 There are limited risks associated directly with the contents of this report. These include:

- Potential for changes to the position as the accounts are finalised and audited; and
- Increased attention on levels of reserves in the context of increased waiting times and unmet health and care needs. This is likely to be a national issue.

11. PUBLIC AND USER INVOLVEMENT AND ENGAGEMENT

11.1 None directly from this report, the unaudited accounts will be available for public scrutiny in July.

12. CONCLUSIONS

12.1 This report provides a provisional summary of the financial performance of the HSCP for 2021/22. It reports a positive financial position with a small underspend against available resources, the repayment of the debt balance owed to Argyll and Bute Council and increased reserves.

12.2 This represents the second year in succession where the HSCP has delivered a surplus. The early repayment of debt frees up significant resource in future years which will enable it to accelerate some of its transformation and improvement plans. Recruitment, staffing vacancies and a general lack of capacity in some areas has constrained the level of service provided during the year and this has contributed to the favourable financial position.

13. DIRECTIONS

	Directions to:	tick
Directions required to Council, NHS Board or both.	No Directions required	√
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

APPENDICES:

Appendix 1 – Provisional Outturn 2021/22
Appendix 2 – Earmarked Reserves as at 31 March 2022
Appendix 3a – Savings fully achieved
Appendix 3b – Savings Carry Forward
Appendix 3c – Savings Cancelled / Reduced

AUTHOR NAME: James Gow, Head of Finance and Transformation
EMAIL: james.gow@argyll-bute.gov.uk

ARGYLL AND BUTE HEALTH AND SOCIAL CARE PARTNERSHIP **APPENDIX 1**

REVENUE BUDGET MONITORING SUMMARY - YEAR TO DATE POSITION AS AT 31 MARCH 2022

Reporting Criteria: +/- £50k or +/- 10%

Service	Actual £000	Budget £000	Variance £000	% Variance	Explanation
COUNCIL SERVICES:					
Chief Officer	151	652	501	76.8%	Overspend due to the remaining debt repayment to Council (£703k) and the proposed transfer of underspend to general reserve (£682k) being shown at Chief Officer for reporting purposes. These are funded by underspends across the other service areas. Additionally over-recovery of charges to clients (£330k) and funding received for the slippage on budget savings (£1.098m) are included here.
Service Development	425	438	13	3.0%	Outwith reporting criteria.
Looked After Children	7,290	7,127	(163)	(2.3%)	Overspend due to demand for residential placements (£499k), partially offset by underspends on adoption (£86k), fostering (£150k) and throughcare (£95k).
Child Protection	2,985	3,071	86	2.8%	Underspend reflects lower than expected demand for contact and welfare services (£45k) and on payments to health boards and other bodies in the Child Protection Committee (£41k).
Children with a Disability	709	879	170	19.3%	Underspend reflects lower spend on external respite placements in Ardlui respite facility (£89k) and underspends on payments to other bodies (£76k) due to demand for service.
Criminal Justice	(35)	121	156	128.9%	Underspends on staffing (£121k) as well as underspends on payments to other bodies (£35k).
Children and Families Central Management Costs	3,032	2,977	(55)	(1.8%)	Overspends on staffing (£43k) as well as combined small overspends in supplies and services.
Older People	37,157	38,443	1,286	3.3%	Underspend reflects reduced demand for external residential care (£630k), underspends within the homecare (£438k) and progressive care services (£136k), higher income from fees and charges in the HSCP care homes (£105k) and underspends within Telecare (£62k). There are also transport related underspends due to Covid-19 restrictions (£55k). This is offset by the non-delivery of agreed savings of £418k. The slippage on savings is further partially offset at Chief Officer level where Covid-19 income from the Scottish Government is credited.
Physical Disability	3,219	3,145	(74)	(2.4%)	Overspend reflects higher than budgeted demand for Supported Living (£219k). Partially offset by an underspend (£12k) in the residential care budget and the intergrated equipment store budget (£112k) due to a positive year end stock adjustment.
Learning Disability	16,698	15,497	(1,201)	(7.8%)	Overspend due to service demand in Supported Living (£879k) and residential care (£148k) as well as slippage on savings (£496k) partially offset by underspends on staff and travel costs in day services (£192k) and payments for respite activity (£71k). The slippage on savings and income from clients is offset at Chief Officer level.
Mental Health	2,913	2,849	(64)	(2.2%)	Overspend mainly due to demand in the residential care budget (£236k) offset partially by underspends within the assessment and care management teams (£85k), payments for addiction support (£23k) and supported living budgets (£34k).
Adult Services Central Management Costs	606	633	27	4.3%	Outwith reporting criteria.
COUNCIL SERVICES TOTAL	**75,150**	**75,832**	**682**	**0.9%**	
HEALTH SERVICES:					**Explanation**
Community & Hospital Services	59,763	58,821	(943)	(1.6%)	Overspend due to unachieved savings, bank, agency and locum costs and unfunded nurse staffing regradings.

Service	Actual £000	Budget £000	Variance £000	% Variance	Explanation
Mental Health and Learning Disability	14,278	14,808	531	3.6%	Underspend due to vacancies within the service.
Children & Families Services	8,713	8,820	106	1.2%	Underspend due to vacancies within the service.
Commissioned Services - NHS GG&C	68,804	68,296	(507)	(0.7%)	Budget overspend due to unfunded element of nationally agreed SLA uplift and an increase in high cost treatments particulary oncology drugs costs charged in March.
Commissioned Services - Other	4,128	4,003	(125)	(3.1%)	Overspend due to increased number of patients receiving TAVI cardiac procedure at GJNH & unfunded element of SLA uplift.
Head of Primary Care	24,962	24,924	(39)	(0.2%)	Outwith reporting criteria.
Other Primary Care Services	10,835	10,835	0	0.0%	Outwith reporting criteria.
Prescribing	20,488	20,366	(123)	(0.6%)	Overspend due to increased volume of prescriptions, new diabetes and cholesterol drugs, patient specific high cost drugs
Public Health	2,988	2,992	4	0.1%	Outwith reporting criteria.
Lead Nurse	3,496	3,577	81	2.3%	Underspend due to staff vacancies and delays on non-pay spend due to Covid.
Management Service	3,087	2,859	(228)	(8.0%)	Overspending due to slippage with the savings programme.
Planning & Performance	2,855	2,691	(164)	(6.1%)	Overspending die to unachieved A&B wide savings
Budget Reserves	0	1,251	1,251	100.0%	Slippage on budget reserves allocations / spend.
Income	(1,944)	(1,758)	186	(10.6%)	Favourable variance due to long stay mental health inpatients from overseas and England.
Estates	9,120	9,091	(30)	(0.3%)	Outwith reporting criteria.
HEALTH SERVICES TOTAL	**231,575**	**231,575**	**0**	**0.0%**	
GRAND TOTAL	**306,725**	**307,407**	**682**	**0.2%**	

APPENDIX 2

Argyll & Bute HSCP - Provisional Reserves as at 31 March 2022

Reserve held by	Reserve Description / Earmarking	Year End Balance £
Health	Additional Band 2-4 staffing	258,971
Health	Best Start Implementation	86,000
Health	ADP Frontline Services	108,979
Health	Medical Assisted Treatments (MAT) Standards	114,114
Health	PCIF	3,061,992
Health	GMS Premises	178,441
Health	Primary Care OOH Funding	231,870
Health	Expansion of Primary Care Estates- leases	38,038
Health	Mental Health & Wellbeing in Primary Care Services	29,712
Health	GP Practices - Sustainability Payments	6,771
Health	Mental Health funding for Pharmacy Recruitment	17,869
Health	Scotgem Funding - A&B Hosp / LIH	7,000
Health	ACT Aros Residences Upgrade	64,200
Health	ScotGEM (upgrade teaching facilities LIH)	6,701
Health	Renovations to Lochgilphead Accommodation	120,000
Health	Oban Accommodation Renovation/Expansion	145,000
Health	Primary Care Education Fund	250,000
Health	ScotGEM - Yr3 Faculty funds Oban	3,500
Health	ScotGEM - Yr3 Faculty funds Lochgilphead	3,500
Health	Further 2021-22 Covid-19 Funding (for 22/23 Covid & remob)	7,796,000
Health	Type 2 Diabetes Framework	31,803
Health	Wellbeing Funding	8,860
Health	Workforce Wellbeing - Primary Care & Social Care	38,038
Health	Workforce Wellbeing - NHS	38,130
Health	21/22 Mental Health Recovery CAHMS	448,705
Health	CAMHS improvement - Intensive Psychiatric Care units	31,381
Health	CAMHS improvement - Intensive Home Treatment Teams	38,038

Health	CAMHS improvement - LD, Forensic & Secure CAMHS	13,313
Health	CAMHS improvement - Out of Hours unscheduled care	22,252
Health	CAMHS improvement - CAMHS liaison teams	33,283
Health	CAMHS improvement - Neurodevelopmental professionals	58,198
Health	TEC Analogue to Digital Funding	50,000
Health	TEC funding to support local scale up (Near Me)	44,902
Health	Technology Enabled Care (Near Me) - Dunoon Broadband	9,000
Health	Additional Elective Activity (Waiting Times)	306,600
Health	ADP Long-acting Buprenorphine (Buvidal 90)	76,259
Health	Trauma Network Tranche 1 (70%) / Tranche 2 (30%)	62,525
Health	Mental Health Support for those hospitalised with Covid 19	26,115
Health	Urgent & Unscheduled Care - Interface Care Programme	133,032
Health	District Nurse Posts	127,015
Health	ASC Nurse Director Support IPC	61,066
Health	Nursing Support for Care Homes	151,386
Health	Diabetic Technologies	275,334
Health	Covid 19 - Vaccines (Alloc 60 & 401 plus 782)	1,210,010
Health	Covid 19 - General Allocation (Covid/PPE/Testing) / Further Covid	1,415,299
Health	20/21 Action 15 / Tranche 2	289,661
Health	Perinatal MH Funding	160,679
Health	21/22 Mental Health Recovery Psych Therapies	94,854
Health	Emergency Covid Funding for Eating Disorders	69,238
Health	Mental Health Recovery Renewal - Facilities Project	285,284
Health	PFG School Nursing Tranche 2	166,783
Health	Ventilation improvement allowance	81,900
Health	Remobilisation of NHS Dental Services	89,604
Health	Electric Speed adj hand pieces	128,885
Health	E-health Strategy Funding	72,400
Health	Cancer Waiting Times	190,583
Health	Fleet Decarbonisation	86,520
Health	Dementia Post Diagnostic Support Service	66,566
Health	Inequalities projects	26,369
Social Care	TEC Analogue to Digital Funding	20,328

Social Care	Mental Health Officer Training	28,221
Social Care	Trauma Training Trials	19,444
Social Care	Winter Planning/Covid funding for Vulnerable Children & Young People	41,726
Social Care	Community Living Change Fund	300,000
Social Care	See Hear Funding	13,658
Social Care	Criminal Justice Transformation Fund	39,890
Social Care	Whole Family Wellbeing Fund	39,000
Social Care	Trauma Traing Programme & Informed Practice	50,000
Social Care	Telecare - Smoke, heat & CO detectors	18,000
Social Care	Care at Home funding	287,913
Social Care	MDT Funding	213,946
Social Care	Interim Care Funding	447,402
Social Care	Transformation and Staff restructuring Learning Disability Services (general reserve)	265,000
Social Care	Service Transformation and Infrastructure Investment (general reserve)	416,528
	Total	**21,249,584**

Health Prior Years	2,621,585
Health 21/22	16,426,943
Social Care Prior Years	463,267
Social Care 21/22	1,737,789
Total	**21,249,584**

This page is intentionally left blank

APPENDIX 3a - FULLY ACHIEVED SAVINGS 2021/22

Ref.	Savings Description	Target £' 000	Achieved £' 000
Social Work			
1819-7	Thomson Court	10	10
1819-14	Redesign of Internal and External Childrens Residential Placements	22	22
1819-18	Review provision of HSCP care homes	99	99
1819-19a	Review and Redesign of Learning Disability Services - Sleepovers and Technology - Kintyre	3	3
1819-19a	Review and Redesign of Learning Disability Services - Sleepovers and Technology - Bute	1	1
1819-19a	Review and Redesign of Learning Disability Services - Sleepovers and Technology - Helensburgh	16	16
1819-19a	Review and Redesign of Learning Disability Services - Packages of Care Mid Argyll	34	34
1819-19a	Review and Redesign of Learning Disability Services - Packages of Care Kintyre	26	26
1819-19a	Review and Redesign of Learning Disability Services - Packages of Care Cowal	11	11
1819-19a	Review and Redesign of Learning Disability Services - Packages of Care Helensburgh	13	13
1819-19c	Review and Redesign of Learning Disability Rothesay Resource Centre	3	3
1819-19c	Review and Redesign of Learning Disability Assist Cowal Resource Centre	30	30
1819-25	Older People Day/Resource Centre - Address high levels of management - consolidate opening hours - shared resource	57	57
1920-16	Redesign review of Criminal Justice service to become self funding	20	20
1920-40	Implement best practice approaches for care at home and re-ablement across all areas following Bute pilot	300	300
1920-41	Extend use of external home care transferring hours as gaps occur	33	33
1920-43	Cap on overtime	87	87
1920-45	Planned changes in staffing for Bowman Court in line with Lorne Campbell Court structure	28	28
2021-5	Bring staffing within ECCT teams and Mull Progressive Care Centre into line with best practice	85	85
2021-7a	Review of provisioning of day services and remodel considering options of greater third sector involvement aiming for 10% reduction in cost (currently underspending by c £70k) - Dementia Rothesay	10	10
2021-7a	Review of provisioning of day services and remodel considering options of greater third sector involvement aiming for 10% reduction in cost (currently underspending by c £70k) - Oban Day Centre	10	10
2021-7a	Review of provisioning of day services and remodel considering options of greater third sector involvement aiming for 10% reduction in cost (currently underspending by c £70k) - Struan Day Centre	18	18
2021-32	Review housing support services and remove where not required for LD and PD clients - Kintyre	19	19
2021-42a	Integrated equipment store - increased consistency in prescribing	70	70
2021-46	Improved rostering of staff for school hostels	6	6
2122-08	Pay for care home placements for older people in line with national contract with no added enhancements	70	70
2122-09	When a new client is assessed as requiring 24 hour care and refuses care home placement, offer to fund a package of care at home up to £30k, allowing the service user to fund the additional hours of care if they chose to remain at home	60	60
2122-12	Reduce payments to voluntary organisations for non-contracted services	60	60
2122-19	remove existing underspends in contact & welfare budget	50	50
2122-20	reduction in staff travel	20	20
2122-21	align budgets with spending levels in sundry Social work Childrens budgets	24	24
2122-22	Remove underspend in fostering budget	70	70
2122-23	Remove vacant assessment and reviewing officer post	50	50
2122-24	Community justice to be self funding	50	50
2122-47	Reduce care home placements budgets as numbers have been falling pre Covid	90	90
2122-49	Reduce social work travel budget	16	16
2122-50	Reduction and realignment of the Development and Flexibility Budget Lines £13k and sundry other social work underspends £11k	24	24
2122-51	Do not fill vacant posts in day services as service is being re-designed	30	30
2122-52	Reduction in mental health team travel £5.5k	6	6
2122-53	Removal of out of area day services no longer required	13	13
2122-55	Reduction in travel for Social Work Mental health & Addictions team travel	2	2
2122-57	Savings from review of Jeans Bothy SLA already completed	5	5
2122-70	From Social Work: unallocated growth monies for 2020/21	782	782
2122-71b	Non-recurring vacancy savings for one year only, reflecting continued reduction of activity in 2021/22 due to pandemic	250	250
Health			
1819-53	Vehicle Fleet Services (see also 2021-57)	18	18
1920-3	Health Promotion Discretionary Budgets	54	54
1920-8a	GP Prescribing	324	324
1920-8b	GP Prescribing	500	500
1920-38a	LIH Theatre nurse staffing - HAK112	30	30
2021-57	Fleet management - electric vehicles, improved accuracy of mileage claims using postcodes; fuel savings through use of telematic data (see also 1819-53)	40	40
2021-58	Additional Income from other Health Boards	200	200
2122-05	Only pay for escort travel where it is essential	35	35
2122-16	Reduce befriender service following review of clients	12	12
2122-17	Encourage clients to have individual tenancies with housing association - they will qualify for benefits covering housing costs - rather than HSCP paying for rents and council tax - encouraging fuller independence for clients	9	9
2122-18	Reduce Senior Dental Officer post by 0.4 WTE	40	40
2122-15a	End grants paid to link clubs, some of which are no longer providing services	2	2
2122-27	staff travel reduction	5	5
2122-28	Reduction in Staff Nurse and Community Children's Nurse hours	16	16
2122-29	slight reduction in admin hours	6	6
2122-34	Oban hospital: outreach clinics £5k; TSSU transfer to N Highland £5k	10	10
2122-39	Bute patient travel £10k	10	10
2122-41	Islay: save admin on patient travel £26k	26	26
2122-45	Helensburgh: Linen services £6.8k, window cleaning £2k	9	9
2122-56	Reduction in travel for Health Mental health & Addictions team travel	3	3
2122-58	review of Community Mental Health SLA with NHS GG&C and improved contract management of this service	30	30
2122-59	HSCP telephony new contract £153k;	153	153
2122-61	re-grade of project manager post in Planning & Performance team	7	7
2122-62	removal of surplus from social prescribing budget	30	30
2122-63	removal of surplus from public engagement £8k	8	8
2122-64	Medical director budget - reduce Travel	4	4
2122-65	Lead Nurse budget reduce Travel £2k and Child Protection £5k	7	7
2021-66	Community dental practices	15	15
2122-67	Finance Hours reduction of 0.6 Band 4 £17k; travel and stationery £3k	20	20
2122-69	People & Change saving on Travel and printing £4k	4	4
2122-71a	Non-recurring vacancy savings for one year only, reflecting continued reduction of activity into 2021/22 due to pandemic	750	750
Total		**5,059**	**5,059**

APPENDIX 3b - PARTIALLY ACHIEVED SAVINGS

Ref.	Savings Description	Target £' 000	Achievement £' 000	Shortfall C/FWD £' 000
Social Work				
2122-01	Align business model for staffing for the 3 children's homes	100	94	6
2122-03	Do not replace independent chair of panel	8	6	2
2122-11	Remove funding for all lunch clubs	29	0	29
2122-02	Carry out hostel review to achieve best value in admin and catering	44	21	23
2021-7b	Review of provisioning of day services and remodel considering options of greater third sector involvement aiming for 10% reduction in cost (currently underspending by c £70k) - Lorn Resource	44	17	27
2021-7b	Review of provisioning of day services and remodel considering options of greater third sector involvement aiming for 10% reduction in cost (currently underspending by c £70k) - Lochside	29	0	29
2021-7b	Review of provisioning of day services and remodel considering options of greater third sector involvement aiming for 10% reduction in cost (currently underspending by c £70k) - Woodlands	27	0	27
2021-7b	Review of provisioning of day services and remodel considering options of greater third sector involvement aiming for 10% reduction in cost (currently underspending by c £70k) - Phoenix	22	0	22
2021-7b	Review of provisioning of day services and remodel considering options of greater third sector involvement aiming for 10% reduction in cost (currently underspending by c £70k) - ASIST	41	0	41
1819-33	Catering, Cleaning and other Ancillary Services	70	0	70
2122-54	Reduction in supported living packages through improved commissioning	30	0	30
Health				
1819-32	Catering & cleaning review	20	0	20
1819-44	Advanced Nurse Practitioners - Oban	14	0	14
1920-38b	Lorn & Islands Hospital staffing	28	7	21
2122-15b	End grants paid to link clubs, some of which are no longer providing services	5	3	2
2021-1	Mental Health redesign of dementia services (excludes commissioned services)	200	0	200
2122-32	1% general efficiency requirement across all hospital budgets	487	301	186
2122-35	Mid Argyll hospital removal of surplus budgets on hotel services £20k, comms £4.3k; GMS out of hours £2k; equipment £1.5k	28	24	4
2122-10	Redirect Oban Integrated Care Funding (used to pay grants to a range of voluntary sector organisations) to pay for day responder service as in other areas	74	60	14
2122-46	Helensburgh outreach clinics £8k; casualty payments £14k,	22	8	14
2122-66	Savings from building rationalisation following increase in home working	100	28	72
1920-22	Dunoon Medical Services (see also 2021-16)	100	0	100
1920-35	Bed reduction savings : Dunoon	150	0	150
2021-2	Standardise procurement of food across all sites and expansion in conjunction with Council for early years	69	0	69
2021-3	AHP - carry out workforce planning and establishment setting to find efficiencies in posts and realign services provided to match	86	0	86
2021-4a	Admin & clerical general productivity / efficiency enhancement via shift to digital working in 2020/21 and 2021/22	100	0	100
2021-4b	Right size admin budgets Mid Argyll and LIH	45	18	27
2021-16	Rationalisation of medical services for Dunoon (adds to 1920-22)	20	0	20
2021-19	Redesign of hotel services to reflect reduction in inpatient numbers	99	0	99
2021-20	Centralised booking of medical records - reduction in admin costs	97	0	97
2021-23	Catering & domestic - spending below budgets	30	0	30
2021-29	Dunoon Gum clinic - underspend	20	0	20
2021-64	Review of Forensic Medical Examiner Costs - Bute & Cowal and Out of hours	50	0	50
2122-04	Bring back urology services from NHS Greater Glasgow & Clyde and offer from Oban Hospital instead	110	0	110
2122-33	centralise lab ordering £20k and theatre stock ordering £5 along with North Highland	25	5	20
2122-43	Oban Patient travel £25k; staff travel £10k	35	25	10
2122-60	Planning & Performance team - reduce budget for travel & printing £3k; Consultant Travel £10k	13	3	10
2122-30	Introduce more re-use of walking frames and improved procurement of musculo-skeletal supplies	20	0	20
2122-36	Campbeltown hospital patients travel £30k	30	0	30
2122-37	Campbeltown hospital catering £14k;	14	12	2
2122-38	Campbeltown hospital sundry underspends comms £6k; portering £1; pharmacy £6k; general management discretionary £5k, transport £2k; GMS out of hours £1.5k	22	9	13
2122-42	Islay: saving on local outreach clinics and accommodation through more remote clinics	15	0	15
		2,572	**641**	**1,931**

APPENDIX 3c - SAVINGS CANCELLED / REDUCED

Ref.	Savings Description	Target £' 000		Achievement £' 000	Shortfall £' 000	Total Reduction £' 000	C/Fwd £' 000
Social Work - Cancelled in Full							
1819-42	Contract Management reducing payments to Commissioned External providers	33		0	33	33	
1819-19b	Review of Ext Residential Learning Disability Placements	194		0	194	194	
1819-22	Adult Care West - Restructure of Neighbourhood Teams (SW & Health)	250		0	250	250	
1819-31	Integrate HSCP Admin, digital Tech and Central Appoint System	104		0	104	104	
1819-46	Adopt a Single Community Team Approach to undertaking Assessment and Care Management	120		0	120	120	
Health - Cancelled in full							
2021-17	Ongoing grip and control of all non-essential expenditure	256		0	256	256	
2021-15	Investment fund savings - reduce spend on Care & repair by £60k originally funded as short term investment	60		0	60	60	
2021-65	Review of support payments to GP practices	50		0	50	50	
2122-25	Remove 0.7 health visitor post following retirements	35		0	35	35	
2122-26	Remove advanced nurse vulnerable groups post	60		0	60	60	
2122-31	Kintyre OT £13; Kintyre Physio £4k; Mid Argyll Physio £4k	21		0	21	21	
2122-44	Oban paramedical supplies £5k	5		0	5	5	
2122-40	Cowal Pharmacy	10		0	10	10	
Social Work Reductions							
1819-19a	Review and Redesign of Learning Disability Services - Packages of Care Lorn	46		22	24	24	0
2021-32	Review housing support services and remove where not required for LD and PD clients - Cowal	39		18	21	7	14
1819-8	Assessment and Care Management	42		28	14	14	
2021-30	Provide sleepovers on exceptional basis or as part of core and cluster, and increase technology provision as alternative - savings on top of £299k for earlier years b/fwd and not yet delivered	50		7	43	43	0
1819-19a	Review and Redesign of Learning Disability Services - Sleepovers and Technology - Mid Argyll	4		2	2	2	0
1819-19a	Review and Redesign of Learning Disability Services - Sleepovers and Technology - Lorn	15		0	15	15	0
1819-19a	Review and Redesign of Learning Disability Services - Sleepovers and Technology - Cowal	12		2	10	10	0
2021-32	Review housing support services and remove where not required for LD and PD clients - Mid Argyll	26		0	26	8	18
2021-32	Review housing support services and remove where not required for LD and PD clients - Lorn	45		0	45	31	14
2021-32	Review housing support services and remove where not required for LD and PD clients - Helensburgh	45		7	38	28	10
1819-19b	Review and Redesign of Learning Disability Services - Sleepovers and Technology Argyll Wide	118		22	96	46	50
Health Reductions							
1920-4	Review of Service Contracts	64		0	64	44	20
Total Cancelled / Reduced		**1,704**		**108**	**1,596**	**1,470**	**126**

This page is intentionally left blank

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Date of Meeting: 25 May 2022

Title of Report: Updated Model Code of Conduct and Argyll & Bute IJB Standing Orders

Presented by: Charlotte Craig

The Board is asked to:

- Agree and note the amendment to the standing orders on the basis of guidance from Scottish Government
- Note the excerpt Code of Conduct will be submitted to Scottish Government on 10 June 2022 for review

1. EXECUTIVE SUMMARY

The Model Code of Conduct was last reviewed in 2014 and Scottish Government acknowledged that society has seen a variety of developments since then. A consultation was undertaken in October 2020 through to February 2021 to contribute to a revised Model Code.

Key areas highlighted were the role of social media, the importance of respectful behaviour and the zero tolerance approach to bullying and harassment. The Model Code has also been reviewed to ensure that it is easier to understand and for board members to take personal ownership for their behaviour.

The updated model was presented to the IJB in January 2022 for approval incorporated into the Standing Orders as with the previous standing Orders.

2. INTRODUCTION

The Ethical Standards in Public Life etc. (Scotland) Act 2000 requires Scottish Ministers to issue a Code of Conduct for Councillors (Councillors Code) and a Model Code of Conduct for members of devolved public bodies (Members' Code) as listed in Schedule 3 of the Act, as amended.

The IJB is required to submit a revised copy to Scottish Government by 10 June 2022 for review.

3. DETAIL OF REPORT

The revised Model Code of Conduct was presented to the IJB as part of the updated Standing Orders in January 2022 where it was approved. Further

guidance from Scottish Government is to submit the Code of Conduct separately as an excerpt for consideration.

The Integration Joint Board is asked to note the following changes which are highlighted in the appendix :

- Paragraph 3.7 Enquiry has been made to reference Chief Officer rather than Chief Executive this will be noted in the review.
- Paragraph 3.1.11 will be retained in reference to collective decision making and oversight of corporate responsibility in delivering partners exercised through staff governance reporting.
- Paragraph 4.15 which now correctly references paragraph 4.20 instead of paragraph 4.19.

The Model Code of Conduct is a statutory document which requires to be followed by all Public Bodies covered by the Ethical Standards Framework. As such changes to the document are minimal, require to be reviewed and approved by Scottish Government to ensure compliance.

4. RELEVANT DATA AND INDICATORS

Scottish Government Consultation and Analysis

5. CONTRIBUTION TO STRATEGIC PRIORITIES

The Model Code of Conduct provides a framework supporting robust governance through member behaviours.

6. GOVERNANCE IMPLICATIONS

6.1 **Financial Impact**

None directly from this report

6.2 **Staff Governance**

None directly from this report

6.3 **Clinical Governance**

None directly from this report

7. PROFESSIONAL ADVISORY

Advisory was provided by the IJB Standards officer contributing to the referenced report in January 2022

8. EQUALITY & DIVERSITY IMPLICATIONS

The Model Code of Conduct seek to reflect developments in society to ensure that the Board is fully aware of developing legislation that supports and equal and diverse society in Argyll & Bute.

9. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

Relevant documentation is stored in compliance with GDPR

10. RISK ASSESSMENT

The Model Code informs the conduct of the Board with the 'Key Principles' guiding the decision making of the Board. This should impact on considerations when assessing risk to the Argyll & Bute Integration Board Area.

11. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

None required for this report

12. CONCLUSIONS

Integration Joint Board Members are invited to approve the updated Standing Orders and where not bound by the code as part of another role they are invited to provide their agreement in writing that they are happy to agree to the Model Code.

13. DIRECTIONS

	Directions to:	tick
Directions required to Council, NHS Board or both.	No Directions required	x
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

REPORT AUTHOR AND CONTACT

Author Name Charlotte Craig
Email charlotte.craig@argyll-bute.gov.uk

This page is intentionally left blank

STANDING ORDERS

ARGYLL AND BUTE INTEGRATION JOINT BOARD

May 2022

Document control

Title	IJB and Committee Terms of Reference
Author	Integration Joint Board
Creation date	Document Control May 2022
Date of version	May 2022

Version history

Version	**Comments**
V3.3	Draft updated Model Code of Conduct in line with advisory from Scottish Government. 3.7 updated to Chief Officer

1. General

These Standing Orders are made under the Public Bodies (Joint Working) (Scotland) Act 2014 and the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014. These Standing Orders shall, as far as applicable be the rules and regulations for the proceedings of Committees and working groups and therefore reference to the term 'Board' in the said Standing Orders should be interpreted accordingly. The term 'Chairperson' shall also be deemed to include the Chairperson of any Committee or working groups but only in relation to such Committees or working groups.

1.2 In these Standing Orders "the Integration Joint Board" shall mean Argyll and Bute Integration Joint Board established in terms of the (SSI 2015/88) Order 2015. ''The Council'' means Argyll & Bute Council and ''The Health Board'' means NHS Highland Health Board.

1.3 Any statutory provision, regulation or direction issued by the Scottish Ministers shall have precedence if they are in conflict with the Standing Orders.

2. Membership

2.1 Voting membership of the Integration Board shall comprise four NHS Highland Board members, nominated by the NHS Board, and four Elected Members of Argyll & Bute Council, (hereinafter referred to as the Council) nominated by the Council.

2.2 Non-voting membership of the Integration Board shall comprise:
a. the Chief Social Work Officer of the Council;
b. the Chief Officer of the Integration Joint Board;
c. the proper officer of the Integration Joint Board appointed under section 95 of the Local Government (Scotland) Act 1973;
d. a registered medical practitioner whose name is included in the list of primary medical services performers prepared by the Health Board in accordance with Regulations made under section 17P of the National Health Service (Scotland) Act 1978;
e. a registered nurse who is employed by the Health Board or by a person or body with which the Health Board has entered into a general medical services contract;
f. a registered medical practitioner employed by the Health Board and not providing primary medical services.
g. one member staff from the Health Board and one member of staff from the Council engaged in the provision of services provided under integration functions;
h. one member in respect of third sector bodies carrying out activities related to health or social care in the area of the local authority;
i. two members in respect of service users residing in the Council area Council;
j. one member in respect of persons providing unpaid care in the Council area of ; and
k. such additional members as the Integration Joint Board sees fit to appoint with the proviso that a member appointed under this paragraph may not be a councillor or a member of the Health Board.
The members appointed under paragraphs (d) to (f) must be determined by the Health Board.

2.3 A member of the Integration Joint Board in terms of 2.2 (a) to (c) will remain a member for as long as they hold the office in respect of which they are appointed. Otherwise, the term of office of Members of the Integration Joint Board shall be for a period of up to 3 years.

2.4 Where a member resigns or otherwise ceases to hold office, the person appointed in his/her place shall be appointed for the unexpired term of the Member they replace.

2.5 On expiry of a member's term of appointment the member shall be eligible for re-appointment provided that he/she remains eligible and is not otherwise disqualified from appointment.

2.6 A voting member appointed under paragraph 2.1 ceases to be a member of the Integration Joint Board if they cease to be either a Councillor or a member of the NHS Board or an Appropriate Person in terms of the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 from the date they cease to be a councillor or member of NHS Board or appropriate person.

2.7 A member of the Integration Joint Board, other than those members referred to in paragraph 2.2(a) to (g, may resign his/her membership at any time during their term of office by giving notice to the Integration Joint Board in writing. The resignation shall take effect from the date notified in the notice or on the date of receipt if no date is notified. If this is a voting member the Integration Joint Board must inform the constituent authority that made the nomination.

2.8 If a member has not attended three consecutive meetings of the Integration Joint Board, and their absence was not due to illness or some other reasonable cause as determined by the Integration Joint Board, the Integration Joint Board may, by giving one month's notice in writing to that member, remove that person from office.

2.9 If a member acts in a way which brings the Integration Joint Board into disrepute or in a way which is inconsistent with the proper performance of the functions of the Integration Joint Board, the Integration Joint Board may remove the member from office with effect from such date as the Integration Joint Board may specify in writing.

2.10 If a member is disqualified under article 8 of the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 during a term of office they are to be removed from office immediately.

2.11 A constituent authority may remove a member which it nominated by providing one month's notice in writing to the member and the Integration Joint Board. (Article 14.1)

2.12 If a member is unable to attend a meeting, a suitably experienced proxy may be appointed by the constituent authority which nominated the member. The appointment of such proxy members will be subject to the same rules and procedures for members. Proxy members shall receive papers for meetings of the Integration Joint Board and shall be entitled to attend or vote at a meeting, only in the absence of the principal member they represent. If the Chairperson or Vice Chairperson is unable to attend a

meeting of the Integration Joint Board, any depute member attending the meeting may not preside over that meeting.

2.13 The acts, meetings or proceedings of the Integration Joint Board shall not be invalidated by any defect in the appointment of any member.

2.14 Where there is a temporary vacancy in the voting membership of the Integration Joint Board, the vote which would have been exercisable by a member appointed to that vacancy may be exercised jointly by the other members nominated by the relevant constituent authority. Where two or more temporary vacancies occur, or a temporary vacancy remains unfilled for longer than 6 months Article 13 of the Order shall be applied. Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014

3. Chairperson and Vice Chairperson

3.1 The Chairperson and Vice Chairperson will be drawn from the NHS Board and the Council voting members of the Integration Joint Board. If a Council member is to serve as Chairperson then the Vice Chairperson will be a member nominated by the NHS Board and vice versa. The first Chairperson of the Integration Joint Board will be appointed on the nomination of the Council.

3.2 The appointment to Chairperson and Vice Chairperson is time limited to a period not exceeding two years and carried out on a rotational basis between Council and NHS Board appointed Chairperson, as agreed in the Integration Scheme. The Council or NHS Board may change their appointee as Chairperson or Vice Chairperson during an appointing period.

3.3 The Vice-Chairperson may act in all respects as the Chairperson of the Integration Joint Board if the Chairperson is absent or otherwise unable to perform his/her duties.

3.4 At every meeting of the Integration Joint Board or committee of the Integration Joint Board the Chairperson, if present, shall preside. If the Chairperson is absent from any meeting the Vice-Chairperson, if present, shall preside. If both the Chairperson and the Vice-Chairperson are absent, a Chairperson shall be appointed from the voting members by the voting members present for that meeting. Any proxy member attending the meeting may not preside over that meeting.

3.5 Powers, authority and duties of Chairperson and Vice-Chairperson.
The Chairperson shall amongst other things:-

(a) Preserve order and ensure that every member has a fair hearing;
(b) Decide on matters of relevancy, competency and order, and whether to have a recess during the meeting, having taken into account any advice offered by the Chief Officer or other relevant officer in attendance at the meeting;
(c) Determine the order in which speakers can be heard;
(d) Ensure that due and sufficient opportunity is given to members who wish to speak to express their views on any subject under discussion;
(e) If requested by any member, ask the mover of a motion, or an amendment, to state its terms;

(f) Maintain order and at his/her discretion, order the exclusion of any member of the public who is deemed to have caused disorder or misbehaved;
(g) The decision of the Chairperson on all matters within his/her jurisdiction shall be final;
(h) Deference shall at all times be paid to the authority of the Chairperson. When he/she rises to speak, the Chairperson shall be heard without interruption; and
(i) Members shall address the Chairperson while speaking;

4. Meetings

4.1 The first meeting of the Integration Joint Board will be convened at a time and place to be determined by the Chairperson. Thereafter Integration Joint Board shall meet at such place and such frequency as may be agreed by the Integration Joint Board.

4.2 The Chairperson may convene special meetings if it appears to him/her that there are items of urgent business to be considered. Such meetings will be held at a time, date and venue as determined by the Chairperson. If the Office of Chairperson is vacant, or if the Chairperson is unable to act for any reason the Vice-Chairperson may at any time call such a meeting.

4.3 If the Chairperson refuses to call a meeting of the Integration Joint Board after a requisition for that purpose specifying the business proposed to be transacted, signed by at least two thirds of the voting members, has been presented to the Chairperson or if, without so refusing, the Chairperson does not call a meeting within seven days after such requisition has been presented, those members who presented the requisition may forthwith call a meeting provided no business shall be transacted at the meeting other than specified in the requisition.

4.4 Adequate provision will be made to allow for members to attend a meeting of the Integration Joint Board or a committee of the Integration Joint Board either by being present together with other members in a specified place, or in any other way which enables members to participate despite not being present with other members in a specified place.

5. Notice of Meeting
5.1 Before each meeting of the Integration Joint Board, or a committee of the Integration Joint Board, a notice of the meeting, specifying the time, place and business to be transacted at it and agreed by the Chairperson, or by a member authorised by the Chairperson to agree on his/her behalf, shall be delivered to every member by electronic means so as to be available to them at least five full working days before the meeting. Failure of service of the notice on any member shall not affect the validity of anything done at a meeting.

5.2 In the case of a meeting of the Integration Joint Board called by members in default of the Chairperson, the notice is to be signed by those members who requisitioned the meeting.

5.3 At all ordinary or special meetings of the Integration Joint Board, no business other than that on the agenda shall be discussed or adopted except where by reason of

special circumstances, which shall be specified in the minutes, the Chairperson is of the opinion that the item should be considered at the meeting as a matter of urgency.

6. Quorum

6.1 No business shall be transacted at a meeting of the Integration Joint Board unless there are present, and entitled to vote both Council and NHS Board members and at least one half of the voting members of the Integration Joint Board are present.

6.2 If within ten minutes after the time appointed for the commencement of a meeting of the Integration Joint Board, a quorum is not present, the meeting will stand adjourned to such date and time as may be fixed and the minute of the meeting will disclose the fact.

7. Codes of Conduct and Conflicts of Interest

7.1 Members of the Integration Joint Board shall subscribe to and comply with both the Standards in Public Life - Code of Conduct for Members of Devolved Public Bodies and Councillors Code of Conduct and Guidance made in respect thereto which are deemed to be incorporated into these Standing Orders. All members who are not already bound by the terms of either Code shall be obliged before taking up membership, to agree in writing to be bound by the terms of the Code of Conduct for Members of Devolved Public Bodies.

7.2 If any member has a financial or non-financial interest as defined in the Councillors' Code of Conduct or the Code of Conduct of Members of Devolved Public Bodies and is present at any meeting at which the matter is to be considered, he/she must as soon as practical, after the meeting starts, disclose that he/she has an interest and the nature of that interest and if he/she is precluded from taking part in consideration of that matter.

7.3 If a member or any associate of theirs has any pecuniary or any other interest direct or indirect, in any contract or proposed contract or other matter and that member is present at a meeting of the Integration Joint Board, that member shall disclose the fact and the nature of the relevant interest and shall not be entitled to vote on any question with respect to it. A member shall not be treated as having any interest in any contract or matter if it cannot reasonably be regarded as likely to significantly affect or influence the voting by that member on any question with respect to that contract or matter.

7.4 Where an interest is disclosed, the other members present at the meeting in question must decide whether the member declaring the interest is to be prohibited from taking part in discussion of or voting on the item of business.

8. Adjournment of Meetings

8.1 A meeting of the Integration Joint Board may be adjourned to another date, time or place by a motion, which shall be moved and seconded and put to the meeting without discussion. If such a motion is carried by a simple majority of those present and entitled to vote, the meeting shall be adjourned to the day, time and place

specified in the motion. In addition the Chairperson may adjourn the meeting at their sole discretion.

9. Disclosure of Information

9.1 No member or officer shall disclose to any person any information which falls into the following categories:-

- Confidential information within the meaning of Section 50(a) (2) of the Local Government (Scotland) Act 1973.
- The full document, or any part of any document marked "not for publication by virtue of the appropriate paragraph of Part 1 of Schedule 7A of the Local Government (Scotland) Act 1973, unless and until the document has been made available to the public or press under section 50B of the said 1973 Act.
- Any information regarding proceedings of the Integration Joint Board from which the public have been excluded unless or until disclosure has been authorised by the Integration Joint Board or the information has been made available to the press or to the public under the terms of the relevant legislation.

9.2 Without prejudice to the foregoing no member shall use or disclose to any person any confidential and/or exempt information coming to his/her knowledge by virtue of his/her office as a member where such disclosure would be to the advantage of the member or of anyone known to him/her or which would be to the disadvantage of the Integration Joint Board.

10. Recording of Proceedings

No sound, film, video tape, digital or photographic recording of the proceedings of any meeting shall be made without prior written approval of the Integration Joint Board.

11. Admission of Press and Public

11.1 Subject to the extent of the accommodation available and except in relation to items certified as exempt, meetings of the Integration Joint Board shall be open to the public. The Chief Officer shall be responsible for giving public notice of the time and place of each meeting of the Integration Joint Board by posting within the main offices of the Integration Joint Board not less than five days before the date of each meeting.

11.2 The Integration Joint Board may by resolution at any meeting exclude the press and public during consideration of any item of business where it is likely, in view of the nature of the business to be transacted or of the nature of the proceedings, that if members of the press and public were present there would be a disclosure to them of exempt information as defined in Schedule 7(A) of the Local Government (Scotland) Act 1973 Act or it is likely that confidential information would be disclosed in breach of an obligation of confidence.

11.3 Every meeting of the Integration Joint Board shall be open to the public but these provisions shall be without prejudice to the Integration Joint Board's powers of exclusion in order to suppress or prevent disorderly conduct or other misbehaviour at a meeting. The Integration Joint Board may exclude or eject from a meeting a member or members of the press and public whose presence or conduct is impeding the work or proceedings of the Integration Joint Board.

12. Alteration, Deletion and Rescission of Decisions of the Integration Joint Board

Except insofar as required by reason of illegality, no motion to alter, delete or rescind a decision of the Integration Joint Board will be competent within six months from the decision, unless a decision is made prior to consideration of the matter to suspend this Standing Order in terms of Standing Order 13.

13. Suspension, Deletion or Amendment of Standing Orders

Any one or more of the Standing Orders in the case of emergency as determined by the Chairperson upon motion may be suspended, amended or deleted at any meeting so far as regards any business at such meeting provided that two thirds of the members of the Integration Joint Board present and voting shall so decide. Any motion to suspend Standing Orders shall state the number or terms of the Standing Order(s) to be suspended.

14. Motions, Amendment and Debate

14.1 It will be competent for any Member of the Integration Joint Board at a meeting of the Integration Joint Board to move a motion directly arising out of the business before the meeting.

14.2 No member, with the exception of the mover of the motion or amendment, will speak supporting the motion or amendment until the same will have been seconded.

14.3 Subject to the right of the mover of a motion, and the mover of an amendment, to reply, no member will speak more than once on the same question at any meeting of the Integration Joint Board except:-

- On a question of Order
- With the permission of the Chairperson
- In explanation or to clear up a misunderstanding in some material part of his/her speech.

In all of the above cases no new matter will be introduced.

14.4 The mover of an amendment and thereafter the mover of the original motion will have the right of reply for a period of not more than 5 minutes. He/she will introduce no new matter and once a reply in commenced, no other member will speak on the subject of debate. Once these movers have replied, the discussion will be held closed and the Chairperson will call for the vote to be taken.

14.5 Amendments must be relevant to the motions to which they relate and no member will be at liberty to move or second more than one amendment to any motion, unless the mover of an amendment has failed to have it seconded.

14.6 It will be competent for any member who has not already spoken in a debate to move the closure of such debate. On such motion being seconded, the vote will be taken, and if a majority of the members present vote for the motion, the debate will be closed. However, closure is subject to the right of the mover of the motion and of the

amendment(s) to reply. Thereafter, a vote will be taken immediately on the subject of the debate.

14.7 Any member may indicate his/her desire to ask a question or offer information immediately after a speech by another member and it will be the option of the member to whom the question would be directed or information offered to decline or accept the question or offer of information.

14.8 When a motion is under debate, no other motion or amendment will be moved except in the following circumstances:

- to adjourn the debate; or
- to close the debate.

14.9 A motion or amendment once moved and seconded cannot be altered or withdrawn unless with the consent of the majority of those present.

14.10 Any member who wishes to propose a motion for consideration by the Integration Joint Board shall give written notice of that motion to the Chairperson, at least 10 full working days prior to the meeting.

15. Voting

15.1 The IJB operating principle is partnership, cooperation and collaboration and members' task will be to ensure that the IJB operates by consensus in its decision making where possible.

15.2 Only the four members nominated by the NHS Board, and the four members appointed by the Council shall be entitled to vote. Voting shall be by show of hands.

15.3 In the case of an equality of votes the Chairperson shall not have a second or casting vote. Where there is more than one amendment then the voting will proceed until one proposition has obtained an overall majority of the members taking part in the vote. In such a circumstance the proposition with the fewest votes will drop out and a further vote or votes will be taken on those that remain until the overall majority is achieved or there is only a motion and amendment before the meeting in which case the proposition with the most votes will prevail. If the voting members do not agree at the time on a proposed means of resolving a dispute at a meeting of the Integration Joint Board the matter will be continued to the next meeting of the Integration Joint Board and if there is no resolution at that further meeting then the matter shall be dealt with in terms of the formal dispute resolution mechanism specified in the Integration Scheme. Standing Order 12 shall not preclude reconsideration of any such item within the 6 month period following the meeting which failed to reach a decision.

16. Minutes

16.1 The names of the members and others attending a meeting of the Integration Joint Board shall be recorded in the minutes of the meeting.

16.2 The minutes of the proceedings of each meeting of the Integration Joint Board or a committee, including any decision or resolution made by that meeting, shall be drawn up and submitted to the next ensuing meeting of the Integration Joint Board or the committee after which they must be signed by the person presiding at that meeting. A minute purporting to be so signed shall be received in evidence without further proof.

17. Committees and Working Groups

17.1 The Integration Joint Board may establish any committee or working group as may be required from time to time but each working group shall have a defined time span as may be determined by the Integration Joint Board.

17.2 The membership, Chairperson, remit, powers and quorum of any committee or working groups will be determined by the Integration Joint Board. Any committee established must include voting members, and must include an equal number of the voting members appointed by the Health Board on the one hand and the Council on the other hand. Any decision relating to the carrying out of functions under the Act or to integration functions taken by a committee established under 17.1 must be agreed by a majority of the votes of the voting members who are members of the committee

17.3 Agendas for consideration at a committee or working group will be issued by electronic means to all members no later than five days (not including Saturday and Sunday) prior to the start of the meeting.

CONTENTS

SECTION 1: INTRODUCTION TO THE MODEL CODE OF CONDUCT

1.1 This Code has been issued by the Scottish Ministers, with the approval of the Scottish Parliament, as required by the Ethical Standards in Public Life etc. (Scotland) Act 2000 (the "Act").

1.2 The purpose of the Code is to set out the conduct expected of those who serve on the boards of public bodies in Scotland.

1.3 The Code has been developed in line with the nine key principles of public life in Scotland. The principles are listed in Section 2 and set out how the provisions of the Code should be interpreted and applied in practice.

My Responsibilities

1.4 I understand that the public has a high expectation of those who serve on the boards of public bodies and the way in which they should conduct themselves in undertaking their duties. I will always seek to meet those expectations by ensuring that I conduct myself in accordance with the Code.

1.5 I will comply with the substantive provisions of this Code, being sections 3 to 6 inclusive, in all situations and at all times where I am acting as a board member of my public body, have referred to myself as a board member or could objectively be considered to be acting as a board member.

1.6 I will comply with the substantive provisions of this Code, being sections 3 to 6 inclusive, in all my dealings with the public, employees and fellow board members, whether formal or informal.

1.7 I understand that it is my personal responsibility to be familiar with the provisions of this Code and that I must also comply with the law and my public body's rules, standing orders and regulations. I will also ensure that I am familiar with any guidance or advice notes issued by the Standards Commission for Scotland ("Standards Commission") and my public body, and endeavour to take part in any training offered on the Code.

1.8 I will not, at any time, advocate or encourage any action contrary to this Code.

1.9 I understand that no written information, whether in the Code itself or the associated Guidance or Advice Notes issued by the Standards Commission, can provide for all circumstances. If I am uncertain about how the Code applies, I will seek advice from the Standards Officer of my public body, failing whom the Chair or Chief Executive of my public body. I note that I may also

choose to seek external legal advice on how to interpret the provisions of the Code.

Enforcement

1.10 Part 2 of the Act sets out the provisions for dealing with alleged breaches of the Code, including the sanctions that can be applied if the Standards Commission finds that there has been a breach of the Code. More information on how complaints are dealt with and the sanctions available can be found at Annex A.

SECTION 2: KEY PRINCIPLES OF THE MODEL CODE OF CONDUCT

2.1 The Code has been based on the following key principles of public life. I will behave in accordance with these principles and understand that they should be used for guidance and interpreting the provisions in the Code.

2.2 I note that a breach of one or more of the key principles does not in itself amount to a breach of the Code. I note that, for a breach of the Code to be found, there must also be a contravention of one or more of the provisions in sections 3 to 6 inclusive of the Code.

The key principles are:

Duty
I have a duty to uphold the law and act in accordance with the law and the public trust placed in me. I have a duty to act in the interests of the public body of which I am a member and in accordance with the core functions and duties of that body.

Selflessness
I have a duty to take decisions solely in terms of public interest. I must not act in order to gain financial or other material benefit for myself, family or friends.

Integrity
I must not place myself under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence me in the performance of my duties.

Objectivity
I must make decisions solely on merit and in a way that is consistent with the functions of my public body when carrying out public business including making appointments, awarding contracts or recommending individuals for rewards and benefits.

Accountability and Stewardship

I am accountable to the public for my decisions and actions. I have a duty to consider issues on their merits, taking account of the views of others and I must ensure that my public body uses its resources prudently and in accordance with the law.

Openness

I have a duty to be as open as possible about my decisions and actions, giving reasons for my decisions and restricting information only when the wider public interest clearly demands.

Honesty

I have a duty to act honestly. I must declare any private interests relating to my public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership

I have a duty to promote and support these principles by leadership and example, and to maintain and strengthen the public's trust and confidence in the integrity of my public body and its members in conducting public business.

Respect

I must respect all other board members and all employees of my public body and the role they play, treating them with courtesy at all times. Similarly, I must respect members of the public when performing my duties as a board member.

SECTION 3: GENERAL CONDUCT

Respect and Courtesy

3.1 I will treat everyone with courtesy and respect. This includes in person, in writing, at meetings, when I am online and when I am using social media.

3.2 I will not discriminate unlawfully on the basis of race, age, sex, sexual orientation, gender reassignment, disability, religion or belief, marital status or pregnancy/maternity; I will advance equality of opportunity and seek to foster good relations between different people.

3.3 I will not engage in any conduct that could amount to bullying or harassment (which includes sexual harassment). I accept that such conduct is completely unacceptable and will be considered to be a breach of this Code.

3.4 I accept that disrespect, bullying and harassment can be:

a) a one-off incident,
b) part of a cumulative course of conduct; or
c) a pattern of behaviour.

3.5 I understand that how, and in what context, I exhibit certain behaviours can be as important as what I communicate, given that disrespect, bullying and harassment can be physical, verbal and non-verbal conduct.

3.6 I accept that it is my responsibility to understand what constitutes bullying and harassment and I will utilise resources, including the Standards Commission's guidance and advice notes, my public body's policies and training material (where appropriate) to ensure that my knowledge and understanding is up to date.

3.7 Except where it is written into my role as Board member, and / or at the invitation of the Chief Officer, I will not become involved in operational management of my public body. I acknowledge and understand that operational management is the responsibility of the Chief Officer and Executive Team.

3.8 I will not undermine any individual employee or group of employees, or raise concerns about their performance, conduct or capability in public. I will raise any concerns I have on such matters in private with senior management as appropriate.

3.9 I will not take, or seek to take, unfair advantage of my position in my dealings with employees of my public body or bring any undue influence to bear on employees to take a certain action. I will not ask or direct employees to do something which I know, or should reasonably know, could compromise them or prevent them from undertaking their duties properly and appropriately.

3.10 I will respect and comply with rulings from the Chair during meetings of:

a) my public body, its committees; and
b) any outside organisations that I have been appointed or nominated to by my public body or on which I represent my public body.

3.11 I will respect the principle of collective decision-making and corporate responsibility. This means that once the Board has made a decision, I will support that decision, even if I did not agree with it or vote for it.

Remuneration, Allowances and Expenses

3.12 I will comply with the rules, and the policies of my public body, on the payment of remuneration, allowances and expenses.

Gifts and Hospitality

3.13 I understand that I may be offered gifts (including money raised via crowdfunding or sponsorship), hospitality, material benefits or services ("gift or hospitality") that may be reasonably regarded by a member of the public with knowledge of the relevant facts as placing me under an improper obligation or being capable of influencing my judgement.

3.14 I will never **ask for** or **seek** any gift or hospitality.

3.15 I will refuse any gift or hospitality, unless it is:

a) a minor item or token of modest intrinsic value offered on an infrequent basis;
b) a gift being offered to my public body;
c) hospitality which would reasonably be associated with my duties as a board member; or
d) hospitality which has been approved in advance by my public body.

3.16 I will consider whether there could be a reasonable perception that any gift or hospitality received by a person or body connected to me could or would influence my judgement.

3.17 I will not allow the promise of money or other financial advantage to induce me to act improperly in my role as a board member. I accept that the money or advantage (including any gift or hospitality) does not have to be given to me directly. The offer of monies or advantages to others, including community groups, may amount to bribery, if the intention is to induce me to improperly perform a function.

3.18 I will never accept any gift or hospitality from any individual or applicant who is awaiting a decision from, or seeking to do business with, my public body.

3.19 If I consider that declining an offer of a gift would cause offence, I will accept it and hand it over to my public body at the earliest possible opportunity and ask for it to be registered.

3.20 I will promptly advise my public body's Standards Officer if I am offered (but refuse) any gift or hospitality of any significant value and / or if I am offered any gift or hospitality from the same source on a repeated basis, so that my public body can monitor this.

3.21 I will familiarise myself with the terms of the Bribery Act 2010, which provides for offences of bribing another person and offences relating to being bribed.

Confidentiality

3.22 I will not disclose confidential information or information which should reasonably be regarded as being of a confidential or private nature, without the express consent of a person or body authorised to give such consent, or unless required to do so by law. I note that if I cannot obtain such express consent, I should assume it is not given.

3.23 I accept that confidential information can include discussions, documents, and information which is not yet public or never intended to be public, and information deemed confidential by statute.

3.24 I will only use confidential information to undertake my duties as a board member. I will not use it in any way for personal advantage or to discredit my public body (even if my personal view is that the information should be publicly available).

3.25 I note that these confidentiality requirements do not apply to protected whistleblowing disclosures made to the prescribed persons and bodies as identified in statute.

Use of Public Body Resources

3.26 I will only use my public body's resources, including employee assistance, facilities, stationery and IT equipment, for carrying out duties on behalf of the public body, in accordance with its relevant policies.

3.27 I will not use, or in any way enable others to use, my public body's resources:

a) imprudently (without thinking about the implications or consequences);
b) unlawfully;
c) for any political activities or matters relating to these; or
d) improperly.

Dealing with my Public Body and Preferential Treatment

3.28 I will not use, or attempt to use, my position or influence as a board member to:

a) improperly confer on or secure for myself, or others, an advantage;
b) avoid a disadvantage for myself, or create a disadvantage for others or
c) improperly seek preferential treatment or access for myself or others.

3.29 I will avoid any action which could lead members of the public to believe that preferential treatment or access is being sought.

3.30 I will advise employees of any connection, as defined at Section 5, I may have to a matter, when seeking information or advice or responding to a request for information or advice from them.

Appointments to Outside Organisations

3.31 If I am appointed, or nominated by my public body, as a member of another body or organisation, I will abide by the rules of conduct and will act in the best interests of that body or organisation while acting as a member of it. I will also continue to observe the rules of this Code when carrying out the duties of that body or organisation.

3.32 I accept that if I am a director or trustee (or equivalent) of a company or a charity, I will be responsible for identifying, and taking advice on, any conflicts of interest that may arise between the company or charity and my public body.

SECTION 4: REGISTRATION OF INTERESTS

4.1 The following paragraphs set out what I have to register when I am appointed and whenever my circumstances change. The register covers my current term of appointment.

4.2 I understand that regulations made by the Scottish Ministers describe the detail and timescale for registering interests; including a requirement that a board member must register their registrable interests within one month of becoming a board member, and register any changes to those interests within one month of those changes having occurred.

4.3 The interests which I am required to register are those set out in the following paragraphs. Other than as required by paragraph 4.23, I understand it is not necessary to register the interests of my spouse or cohabitee.

Category One: Remuneration

4.4 I will register any work for which I receive, or expect to receive, payment. I have a registrable interest where I receive remuneration by virtue of being:

a) employed;
b) self-employed;
c) the holder of an office;
d) a director of an undertaking;
e) a partner in a firm;
f) appointed or nominated by my public body to another body; or
g) engaged in a trade, profession or vocation or any other work.

4.5 I understand that in relation to 4.4 above, the amount of remuneration does not require to be registered. I understand that any remuneration received as a board member of this specific public body does not have to be registered.

4.6 I understand that if a position is not remunerated it does not need to be registered under this category. However, unremunerated directorships may need to be registered under Category Two, “Other Roles”.

4.7 I must register any allowances I receive in relation to membership of any organisation under Category One.

4.8 When registering employment as an employee, I must give the full name of the employer, the nature of its business, and the nature of the post I hold in the organisation.

4.9 When registering remuneration from the categories listed in paragraph 4.4 (b) to (g) above, I must provide the full name and give details of the nature of the business, organisation, undertaking, partnership or other body, as appropriate. I recognise that some other employments may be incompatible with my role as board member of my public body in terms of paragraph 6.7 of this Code.

4.10 Where I otherwise undertake a trade, profession or vocation, or any other work, the detail to be given is the nature of the work and how often it is undertaken.

4.11 When registering a directorship, it is necessary to provide the registered name and registered number of the undertaking in which the directorship is held and provide information about the nature of its business.

4.12 I understand that registration of a pension is not required as this falls outside the scope of the category.

Category Two: Other Roles

4.13 I will register any unremunerated directorships where the body in question is a subsidiary or parent company of an undertaking in which I hold a remunerated directorship.

4.14 I will register the registered name and registered number of the subsidiary or parent company or other undertaking and the nature of its business, and its relationship to the company or other undertaking in which I am a director and from which I receive remuneration.

Category Three: Contracts

4.15 I have a registerable interest where I (or a firm in which I am a partner, or an undertaking in which I am a director or in which I have shares of a value as described in paragraph 4.20 below) have made a contract with my public body:

a) under which goods or services are to be provided, or works are to be executed; and
b) which has not been fully discharged.

4.16 I will register a description of the contract, including its duration, but excluding the value.

Category Four: Election Expenses

4.17 If I have been elected to my public body, then I will register a description of, and statement of, any assistance towards election expenses relating to election to my public body.

Category Five: Houses, Land and Buildings

4.18 I have a registrable interest where I own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of my public body.

4.19 I accept that, when deciding whether or not I need to register any interest I have in houses, land or buildings, the test to be applied is whether a member of the public, with knowledge of the relevant facts, would reasonably regard the interest as being so significant that it could potentially affect my responsibilities to my public body and to the public, or could influence my actions, speeches or decision-making.

Category Six: Interest in Shares and Securities

4.20 I have a registerable interest where:

a) I own or have an interest in more than 1% of the issued share capital of the company or other body; or
b) Where, at the relevant date, the market value of any shares and securities (in any one specific company or body) that I own or have an interest in is greater than £25,000.

Category Seven: Gifts and Hospitality

4.21 I understand the requirements of paragraphs 3.13 to 3.21 regarding gifts and hospitality. As I will not accept any gifts or hospitality, other than under the limited circumstances allowed, I understand there is no longer the need to register any.

Category Eight: Non–Financial Interests

4.22 I may also have other interests and I understand it is equally important that relevant interests such as membership or holding office in other public bodies, companies, clubs, societies and organisations such as trades unions and voluntary organisations, are registered and described. In this context, I understand non-financial interests are those which members of the public with knowledge of the relevant facts might reasonably think could influence my actions, speeches, votes or decision-making in my public body (this includes its Committees and memberships of other organisations to which I have been appointed or nominated by my public body).

Category Nine: Close Family Members

4.23 I will register the interests of any close family member who has transactions with my public body or is likely to have transactions or do business with it.

SECTION 5: DECLARATION OF INTERESTS

Stage 1: Connection

5.1 For each particular matter I am involved in as a board member, I will first consider whether I have a connection to that matter.

5.2 I understand that a connection is any link between the matter being considered and me, or a person or body I am associated with. This could be a family relationship or a social or professional contact.

5.3 A connection includes anything that I have registered as an interest.

5.4 A connection does not include being a member of a body to which I have been appointed or nominated by my public body as a representative of my public body, unless:

a) The matter being considered by my public body is quasi-judicial or regulatory; or
b) I have a personal conflict by reason of my actions, my connections or my legal obligations.

Stage 2: Interest

5.5 I understand my connection is an interest that requires to be declared where the objective test is met – that is where a member of the public with knowledge of the relevant facts would reasonably regard my connection to a particular matter as being so significant that it would be considered as being likely to influence the discussion or decision-making.

Stage 3: Participation

5.6 I will declare my interest as early as possible in meetings. I will not remain in the meeting nor participate in any way in those parts of meetings where I have declared an interest.

5.7 I will consider whether it is appropriate for transparency reasons to state publicly where I have a connection, which I do not consider amounts to an interest.

5.8 I note that I can apply to the Standards Commission and ask it to grant a dispensation to allow me to take part in the discussion and decision-making on a matter where I would otherwise have to declare an interest and withdraw (as a result of having a connection to the matter that would fall within the objective test). I note that such an application must be made in advance of any meetings where the dispensation is sought and that I cannot take part in any discussion or decision-making on the matter in question unless, and until, the application is granted.

5.9 I note that public confidence in a public body is damaged by the perception

that decisions taken by that body are substantially influenced by factors other than the public interest. I will not accept a role or appointment if doing so means I will have to declare interests frequently at meetings in respect of my role as a board member. Similarly, if any appointment or nomination to another body would give rise to objective concern because of my existing personal involvement or affiliations, I will not accept the appointment or nomination.

SECTION 6: LOBBYING AND ACCESS

6.1 I understand that a wide range of people will seek access to me as a board member and will try to lobby me, including individuals, organisations and companies. I must distinguish between:

a) any role I have in dealing with enquiries from the public;
b) any community engagement where I am working with individuals and organisations to encourage their participation and involvement, and;
c) lobbying, which is where I am approached by any individual or organisation who is seeking to influence me for financial gain or advantage, particularly those who are seeking to do business with my public body (for example contracts/procurement).

6.2 In deciding whether, and if so how, to respond to such lobbying, I will always have regard to the objective test, which is whether a member of the public, with knowledge of the relevant facts, would reasonably regard my conduct as being likely to influence my, or my public body's, decision-making role.

6.3 I will not, in relation to contact with any person or organisation that lobbies, do anything which contravenes this Code or any other relevant rule of my public body or any statutory provision.

6.4 I will not, in relation to contact with any person or organisation that lobbies, act in any way which could bring discredit upon my public body.

6.5 If I have concerns about the approach or methods used by any person or organisation in their contacts with me, I will seek the guidance of the Chair, Chief Executive or Standards Officer of my public body.

6.6 The public must be assured that no person or organisation will gain better access to, or treatment by, me as a result of employing a company or individual to lobby on a fee basis on their behalf. I will not, therefore, offer or accord any preferential access or treatment to those lobbying on a fee basis on behalf of clients compared with that which I accord any other person or organisation who lobbies or approaches me. I will ensure that those lobbying on a fee basis on behalf of clients are not given to understand that preferential

access or treatment, compared to that accorded to any other person or organisation, might be forthcoming.

6.7 Before taking any action as a result of being lobbied, I will seek to satisfy myself about the identity of the person or organisation that is lobbying and the motive for lobbying. I understand I may choose to act in response to a person or organisation lobbying on a fee basis on behalf of clients but it is important that I understand the basis on which I am being lobbied in order to ensure that any action taken in connection with the lobbyist complies with the standards set out in this Code and the Lobbying (Scotland) Act 2016.

6.8 I will not accept any paid work:

a) which would involve me lobbying on behalf of any person or organisation or any clients of a person or organisation.

b) to provide services as a strategist, adviser or consultant, for example, advising on how to influence my public body and its members. This does not prohibit me from being remunerated for activity which may arise because of, or relate to, membership of my public body, such as journalism or broadcasting, or involvement in representative or presentational work, such as participation in delegations, conferences or other events.

ANNEX A: BREACHES OF THE CODE

Introduction

1. The Ethical Standards in Public Life etc. (Scotland) Act 2000 ("the Act") provided for a framework to encourage and, where necessary, enforce high ethical standards in public life.

2. The Act provided for the introduction of new codes of conduct for local authority councillors and members of relevant public bodies, imposing on councils and relevant public bodies a duty to help their members comply with the relevant code.

3. The Act and the subsequent Scottish Parliamentary Commissions and Commissioners etc. Act 2010 established the Standards Commission for Scotland ("Standards Commission") and the post of Commissioner for Ethical Standards in Public Life in Scotland ("ESC").

4. The Standards Commission and ESC are separate and independent, each with distinct functions. Complaints of breaches of a public body's Code of Conduct are investigated by the ESC and adjudicated upon by the Standards Commission.

5. The first Model Code of Conduct came into force in 2002. The Code has since been reviewed and re-issued in 2014. The 2021 Code has been issued by the Scottish Ministers following consultation, and with the approval of the Scottish Parliament, as required by the Act.

Investigation of Complaints

6. The ESC is responsible for investigating complaints about members of devolved public bodies. It is not, however, mandatory to report a complaint about a potential breach of the Code to the ESC. It may be more appropriate in some circumstances for attempts to be made to resolve the matter informally at a local level.

7. On conclusion of the investigation, the ESC will send a report to the Standards Commission.

Hearings

8. On receipt of a report from the ESC, the Standards Commission can choose to:

   - Do nothing;
   - Direct the ESC to carry out further investigations; or
   - Hold a Hearing.

9. Hearings are held (usually in public) to determine whether the member concerned has breached their public body's Code of Conduct. The Hearing Panel comprises of

three members of the Standards Commission. The ESC will present evidence and/or make submissions at the Hearing about the investigation and any conclusions as to whether the member has contravened the Code. The member is entitled to attend or be represented at the Hearing and can also present evidence and make submissions. Both parties can call witnesses. Once it has heard all the evidence and submissions, the Hearing Panel will make a determination about whether or not it is satisfied, on the balance of probabilities, that there has been a contravention of the Code by the member. If the Hearing Panel decides that a member has breached their public body's Code, it is obliged to impose a sanction.

Sanctions

10. The sanctions that can be imposed following a finding of a breach of the Code are as follows:

- **Censure**: A censure is a formal record of the Standards Commission's severe and public disapproval of the member concerned.
- **Suspension**: This can be a full or partial suspension (for up to one year). A full suspension means that the member is suspended from attending all meetings of the public body. Partial suspension means that the member is suspended from attending some of the meetings of the public body. The Commission can direct that any remuneration or allowance the member receives as a result of their membership of the public body be reduced or not paid during a period of suspension.
- **Disqualification**: Disqualification means that the member is removed from membership of the body and disqualified (for a period not exceeding five years), from membership of the body. Where a member is also a member of another devolved public body (as defined in the Act), the Commission may also remove or disqualify that person in respect of that membership. Full details of the sanctions are set out in section 19 of the Act.

Interim Suspensions

11. Section 21 of the Act provides the Standards Commission with the power to impose an interim suspension on a member on receipt of an interim report from the ESC about an ongoing investigation. In making a decision about whether or not to impose an interim suspension, a Panel comprising of three Members of the Standards Commission will review the interim report and any representations received from the member and will consider whether it is satisfied:

- That the further conduct of the ESC's investigation is likely to be prejudiced if such an action is not taken (for example if there are concerns that the member may try to interfere with evidence or witnesses); or
- That it is otherwise in the public interest to take such a measure. A policy outlining how the Standards Commission makes any decision under Section 21 and the procedures it will follow in doing so, should any such a report be received from the ESC can be found here.

12. The decision to impose an interim suspension is not, and should not be seen as, a finding on the merits of any complaint or the validity of any allegations against a member of a devolved public body, nor should it be viewed as a disciplinary measure.

ANNEX B: DEFINITIONS

“Bullying” is inappropriate and unwelcome behaviour which is offensive and intimidating, and which makes an individual or group feel undermined, humiliated or insulted.

"Chair" includes Board Convener or any other individual discharging a similar function to that of a Chair or Convener under alternative decision-making structures.

“Code” is the code of conduct for members of your devolved public body, which is based on the Model Code of Conduct for members of devolved public bodies in Scotland.

"Cohabitee" includes any person who is living with you in a relationship similar to that of a partner, civil partner, or spouse.

“Confidential Information” includes:

- any information passed on to the public body by a Government department (even if it is not clearly marked as confidential) which does not allow the disclosure of that information to the public;
- information of which the law prohibits disclosure (under statute or by the order of a Court);
- any legal advice provided to the public body; or
- any other information which would reasonably be considered a breach of confidence should it be made public.

"Election expenses" means expenses incurred, whether before, during or after the election, on account of, or in respect of, the conduct or management of the election.

“Employee” includes individuals employed:

- directly by the public body;
- as contractors by the public body, or
- by a contractor to work on the public body’s premises.

“Gifts” a gift can include any item or service received free of charge, or which may be offered or promised at a discounted rate or on terms not available to the general public. Gifts include benefits such as relief from indebtedness, loan concessions, or provision of property, services or facilities at a cost below that generally charged to members of the public. It can also include gifts received directly or gifts received by any company in which the recipient holds a controlling interest in, or by a partnership of which the recipient is a partner.

“Harassment” is any unwelcome behaviour or conduct which makes someone feel offended, humiliated, intimidated, frightened and / or uncomfortable. Harassment can be experienced directly or indirectly and can occur as an isolated incident or as a course of persistent behaviour.

"Hospitality" includes the offer or promise of food, drink, accommodation, entertainment or the opportunity to attend any cultural or sporting event on terms not available to the general public.

"Relevant Date" Where a board member had an interest in shares at the date on which the member was appointed as a member, the relevant date is – (a) that date; and (b) the 5th April immediately following that date and in each succeeding year, where the interest is retained on that 5th April.

"Public body" means a devolved public body listed in Schedule 3 of the Ethical Standards in Public Life etc. (Scotland) Act 2000, as amended.

"Remuneration" includes any salary, wage, share of profits, fee, other monetary benefit or benefit in kind.

"Securities" a security is a certificate or other financial instrument that has monetary value and can be traded. Securities includes equity and debt securities, such as stocks bonds and debentures.

"Undertaking" means:

a) a body corporate or partnership; or
b) an unincorporated association carrying on a trade or business, with or without a view to a profit.

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Date of Meeting: 25 May 2022

Title of Report: Adoption of Model Complaints Handling Procedure of The Scottish Government, Scottish Parliament and Associated Public Authorities in Scotland for the Integration Joint Board

Presented by: Charlotte Craig

The Board is asked to:

- Note this Model Complaints procedure does not reference the complaints handling of each partner body in relation to service provision.
- Formally adopt the sectoral Model Complaints Handling Procedure for the Scottish Government, Scottish Parliament and Associated Public Bodies for the Integration Joint Board

1. EXECUTIVE SUMMARY

After review of current complaints handling procedures for the IJB, it is advised to adopt a separate sectoral Model Complaints Handling Procedure (MCHP) over and above the models applied to both NHS and Social Work adopted by partners.

Within the partnership, the NHS and Social Work have current adopted Model Complaints Handling Procedures in line with guidance. The Local Authority and Social Work model was revised and implemented in 2022.

The NHS was the last public sector to adopt a specific MCHP on 1 April 2017 and this model has not yet been revised.

2. INTRODUCTION

The Model Complaints Handling procedures were revised in 2019 by the SPSO in consultation with all sectors. The SPSO has issued new guidance for effective complaint handling and requires the HSCP and IJB to adopt this by 01 April 2021.

This is complete in respect of service based complaints for the HSCP.

In addition for complaints relating to the actions and processes of the Integration Joint Board (IJB) they must adopt the MCHP for the Scottish Government, Scottish Parliament and Associated Public Authorities.

Where social work services are being delivered under integrated arrangements through a HSCP, the partnership are required to adopt the

Local Authority MCHP, this sits alongside the NHS Complaints Handling Procedure.

The HSCP has a collective complaints handling process in place.

3. DETAIL OF REPORT

3.1 The Health and Social Care Partnership have a compliant complaints procedure which can be found at the link below:

Argyll & Bute HSCP Complaints Handling Procedure

In respect of service based complaints this procedure will direct complaints to the appropriate partner which are then processed according to guidance.

The purpose of the Model Complaints Handling Procedure is to offer a standardised approach to responding to complaints across the Public Bodies of Scotland.

The current Health and Social Care Partnership and Integrated Joint Board complaints handling procedure adopts the procedure and will direct complaints to the relevant partner.

Further to audit review the IJB is in addition required to adopt a sectoral Model Complaints Handling procedure for the Scottish Government, Scottish Parliament and Associated Public Authorities in Scotland **specifically for the IJB**.

What is a complaint?

A complaint under this sectoral model may relate to the following, but is not restricted to this list:

- failure or refusal to provide a service
- inadequate quality or standard of service, or an unreasonable delay in providing a service
- dissatisfaction with one of our policies or its impact on the individual
- failure to properly apply law, procedure or guidance when delivering services
- failure to follow the appropriate administrative process
- conduct, treatment by or attitude of a member of staff or contractor (except where there are arrangements in place for the contractor to handle the complaint themselves: see Complaints about contracted services); or
- disagreement with a decision, (except where there is a statutory procedure for challenging that decision, or an established appeals process followed throughout the sector).

The complaints procedures of partners were updated with subsequent training provided to relevant staff as required through the Local Authority.

Subsequent actions required on behalf of the IJB are as follows:

1. Adoption of the sectoral Model Complaints Handling Procedure
2. Complaints Handling process and reporting mechanism specific to the IJB and public made aware of this and updated on digital presence
3. Training on the new process
4. Annual report on all complaints.

Discussion has been undertaken in conjunction with the IJB Standards Officer in respect of that role and to draft a compliant process which will be submitted to SPSO and the Finance and Policy Committee in the first instance for review and recommendation to the IJB. An initial draft is included in appendix 1.

4. RELEVANT DATA AND INDICATORS

Request for an annual report to the IJB on complaints and performance against this**.**

5. CONTRIBUTION TO STRATEGIC PRIORITIES

Robust governance supports effective function of the IJB.

6. GOVERNANCE IMPLICATIONS

6.1 **Financial Impact**

No financial impact

6.2 **Staff Governance**

No impact on staff governance

6.3 **Clinical Governance**

No impact on clinical or care governance

7. PROFESSIONAL ADVISORY

This will be developed with the approval of Scottish Public Services Ombudsman.

8. EQUALITY & DIVERSITY IMPLICATIONS

A robust complaints process ensures a route for complaint supporting principle of equitable service delivery.

9. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

No issues with GDPR

10. RISK ASSESSMENT

There were no recorded complaints relating to the IJB in the last 12 months. The detail of the Audit seeks the formal adoption of the sectoral Model Complaints Handling procedure to ensure the Integration Joint Board is compliant and delivering best practice.

11. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

None required for this report.

12. CONCLUSIONS

Action required by the IJB is to adopt the sectoral Model Complaints Handling Procedure

13. DIRECTIONS

Directions required to Council, NHS Board or both.	**Directions to:**	tick
	No Directions required	x
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

REPORT AUTHOR AND CONTACT

Author Name Charlotte Craig
Email charlotte.craig@argyll-bute.gov.uk

Argyll & Bute Integration Joint Board

Complaints handling process v 0.1

Document control

Title	Integration Joint Board Complaints Handling Procedure
Author	Integration Joint Board
Creation date	Document Control May 2022
Date of version	May 2022

Version history

Version	**Comments**
V0.1	Draft

External guidance

Version	*Description*	*Date*
1	Published on SPSO website	March 2013
2	Published on SPSO website	January 2020

Contents

The complaints handling process

1. Our Complaints Handling Procedure (CHP) aims to provide a quick, simple and streamlined process for responding to complaints early and locally by capable, well-trained staff. Where possible, we will **resolve** the complaint to the customer's satisfaction. Where this is not possible, we will give the customer a clear and reasoned response to their complaint.

Complaint received

A customer may complain either verbally or in writing, including face-to-face, by phone, letter or email.

Stage 1: Frontline response

For issues that are straightforward and simple, requiring little or no investigation. 'On-the-spot' apology, explanation, or other action to put the matter right

Complaint resolved or a response provided in **five working days** or less (unless there are exceptional circumstances)

Complaints addressed by any member of staff, or alternatively referred to the appropriate point for frontline response

Response normally face-to-face or by telephone (though sometimes we will need to put the decision in writing)

We will tell the customer how to escalate their complaint to stage 2

Stage 2: Investigation

Where the customer is not satisfied with the frontline response, or refuses to engage at the frontline, or where the complaint is complex, serious or 'high-risk'

Complaint acknowledged within **three working days**.

We will contact the customer to clarify the points of complaint and outcome sought (where these are already clear, we will confirm them in the acknowledgement)

Complaint resolved or a definitive response provided within **20 working days** following a thorough investigation of the points raised

Independent external review (SPSO or other)

Where the customer is not satisfied with the stage 2 response from the service provider

The SPSO will assess whether there is evidence of service failure or maladministration not identified by the service provider

Resolution

The complainant and organisation agree what action will be taken to resolve the complaint.

Where a complaint is resolved, it is not usually necessary to continue investigating, although an organisation may choose to do so, for example to identify learning.

We must signpost the customer to stage 2 (for stage 1 complaints) or to the SPSO as usual.

Reporting, recording and learning

Action is taken to improve services on the basis of complaint findings, where appropriate.

We record details of all complaints, the outcome and any action taken, and use this data to analyse themes and trends.

Senior management have an active interest in complaints and use complaints data and analysis to improve services.

Learning is shared throughout the organisation.

Resolving the complaint

2. A complaint is **resolved** when both the Integration Joint Board and the customer agree what action (if any) will be taken to provide full and final resolution for the customer, without making a decision about whether the complaint is upheld or not upheld.

3. We will try to resolve complaints wherever possible, although we accept this will not be possible in all cases.

4. A complaint may be resolved at any point in the complaint handling process, including during the investigation stage. It is particularly important to try to resolve complaints where there is an ongoing relationship with the customer or where the complaint relates to an ongoing issue that may give rise to future complaints if the matter is not fully resolved.

5. It may be helpful to use alternative complaint resolution approaches when trying to resolve a complaint. See **Alternative complaint resolution approaches**.

6. Where a complaint is resolved, we do not normally need to continue looking into it or provide a response on all points of complaint. There must be a clear record of how the complaint was resolved, what action was agreed, and the customer's agreement to this as a final outcome. In some cases it may still be appropriate to continue looking into the issue, for example where there is evidence of a wider problem or potential for useful learning. We will use our professional judgment in deciding whether it is appropriate to continue looking into a complaint that is resolved.

7. In all cases, we must record the complaint outcome (resolved) and any action taken, and signpost the customer to stage 2 (for stage 1 complaints) or to the SPSO as usual (see **Signposting to the SPSO**).

8. If the customer and the Integration Joint Board are not able to agree a resolution, we must follow this CHP to provide a clear and reasoned response to each of the issues raised.

What to do when you receive a complaint

9. Members of staff receiving a complaint should consider four key questions. This will help them to either respond to the complaint quickly (at stage 1) or determine whether the complaint is more suitable for stage 2:

What exactly is the customer's complaint (or complaints)?

10. It is important to be clear about exactly what the customer is complaining about. We may need to ask the customer for more information and probe further to get a full understanding.

11. We will need to decide whether the issue can be defined as a complaint and whether there are circumstances that may limit our ability to respond to the complaint (such as the time limit for making complaints, confidentiality, anonymity or the need for consent). We should also consider whether the complaint is serious, high-risk or high-profile.

12. If the matter is not suitable for handling as a complaint, we will explain this to the customer (and signpost them to SPSO). There is detailed guidance on this step in **Part 2: When to use this procedure**.

13. In most cases, this step will be straightforward. If it is not, the complaint may need to be handled immediately at stage 2 (see **Stage 2: Investigation**).

What does the customer want to achieve by complaining?

14. At the outset, we will clarify the outcome the customer wants. Of course, the customer may not be clear about this, and we may need to probe further to find out what they expect, and whether they can be satisfied.

Can I achieve this, or explain why not?

15. If a staff member handling a complaint can achieve the expected outcome, for example by providing an on-the-spot apology or explain why they cannot achieve it, they should do so.

16. The customer may expect more than we can provide. If so, we will tell them as soon as possible.

17. Complaints which can be resolved or responded to quickly should be managed at stage 1 (see **Stage 1: Frontline response**).

If I cannot respond, who can help?

18. If the complaint is simple and straightforward, but the staff member receiving the complaint cannot deal with it because, for example, they are unfamiliar with the issues or area of service involved, they should pass the complaint to someone who can respond quickly.

19. If it is not a simple and straightforward complaint that can realistically be closed within five working days (or ten, if an extension is appropriate), it should be handled immediately at stage 2. If the customer refuses to engage at stage 1, insisting that they want their complaint investigated, it should be handled immediately at stage 2. See **Stage 2: Investigation**.

Stage 1: Frontline response

20. Frontline response aims to respond quickly (within five working days) to straightforward complaints that require little or no investigation.

21. Any member of staff may deal with complaints at this stage (including the staff member complained about, for example with an explanation or apology). The main principle is to respond to complaints at the earliest opportunity and as close to the point of service delivery as possible.

22. We may respond to the complaint by providing an on-the-spot apology where appropriate, or explaining why the issue occurred and, where possible, what will be done to stop this happening again. We may also explain that, as an organisation that values complaints, we may use the information given when we review service standards in the future. If we consider an apology is appropriate, we may wish to follow the **SPSO guidance on apology.**

23. **Part 2, Appendix 1** gives examples of the types of complaint we may consider at this stage, with suggestions on how to handle them.

24. Complaints which are not suitable for frontline response should be identified early, and handled immediately at **stage 2: investigation**.

Notifying staff members involved

25. If the complaint is about the actions of another staff member, the complaint should be shared with them, where possible, before responding (although this should not prevent us responding to the complaint quickly, for example where it is clear that an apology is warranted).

Timelines

26. Frontline response must be completed within **five working days**, although in practice we would often expect to respond to the complaint much sooner. 'Day one' is always the date of receipt of the complaint (or the next working day if the complaint is received on a weekend or public holiday).

[Organisations may wish to add additional detail on their usual arrangements for receiving and dating of mail and other correspondence – for example if there is a policy to mark correspondence received after a certain time as received the next day.]

Extension to the timeline

27. In exceptional circumstances, a short extension of time may be necessary due to unforeseen circumstances (such as the availability of a key staff member). Extensions must be agreed with an appropriate manager. We will tell the customer about the reasons for the extension, and when they can expect a response. The maximum extension that can be granted is five working days (that is, no more than **ten working days** in total from the date of receipt).

28. If a complaint will take more than five working days to look into, it should be handled at stage 2 immediately. The only exception to this is where the complaint is simple and could normally be handled within five working days, but it is not possible to begin immediately (for example, due to the absence of a key staff member). In such cases, the complaint may still be handled at stage 1 if it is clear that it can be handled within the extended timeframe of up to ten working days.

29. If a complaint has not been closed within ten working days, it should be escalated to stage 2 for a final response.

30. **Appendix 1** provides further information on timelines.

Closing the complaint at the frontline response stage

31. If we convey the decision face-to-face or on the telephone, we are not required to write to the customer as well (although we may choose to). We must:

    - tell the customer the outcome of the complaint (whether it is resolved, upheld, partially upheld or not upheld)
    - explain the reasons for our decision (or the agreed action taken to resolve the complaint (see **Resolving the complaint**)); and
    - explain that the customer can escalate the complaint to stage 2 if they remain dissatisfied and how to do so (we should not signpost to the SPSO until the customer has completed stage 2).

32. We will keep a full and accurate record of the decision given to the customer. If we are not able to contact the customer by phone, or speak to them in person, we will provide a written response to the complaint where an email or postal address is provided, covering the points above.

33. If the complaint is about the actions of a particular staff member/s, we will share with them any part of the complaint response which relates to them, (unless there are compelling reasons not to).

34. The complaint should then be closed and the complaints system updated accordingly.

35. At the earliest opportunity after the closure of the complaint, the staff member handling the complaint should consider whether any learning has been identified. See **Part 4: Learning from complaints.**

Stage 2: Investigation

36. Not all complaints are suitable for frontline response and not all complaints will be satisfactorily addressed at that stage. Stage 2 is appropriate where:

    - the customer is dissatisfied with the frontline response or refuses to engage at the frontline stage, insisting they wish their complaint to be investigated. Unless exceptional circumstances apply, the customer must escalate the complaint within six months of when they first knew of the problem or within two months of the stage 1 response, whichever is later (see **Part 2: Time limits for making a complaint**)

    - the complaint is not simple and straightforward (for example where the customer has raised a number of issues, or where information from several sources is needed before we can establish what happened and/or what should have happened); or

    - the complaint relates to serious, high-risk or high-profile issues (see **Part 2: Serious, high-risk or high-profile complaints**).

37. An investigation aims to explore the complaint in more depth and establish all the relevant facts. The aim is to resolve the complaint where possible, or to give the customer a full, objective and proportionate response that represents our final position. Wherever possible, complaints should be investigated by someone not involved in the complaint (for example, a line manager or a manager from a different area).

38. Details of the complaint must be recorded on the complaints system. Where appropriate, this will be done as a continuation of frontline response. If the investigation stage follows a frontline response, the officer responsible for the investigation should have access to all case notes and associated information.

39. The beginning of stage 2 is a good time to consider whether complaint resolution approaches other than investigation may be helpful (see **Alternative complaint resolution approaches**).

Acknowledging the complaint

40. Complaints must be acknowledged within three working days of receipt at stage 2.

41. We must issue the acknowledgement in a format which is accessible to the customer, taking into account their preferred method of contact.

42. Where the points of complaint and expected outcomes are clear from the complaint, we must set these out in the acknowledgement and ask the customer to get in touch with us immediately if they disagree. See **Agreeing the points of complaint and outcome sought.**

43. Where the points of complaint and expected outcomes are not clear, we must tell the customer we will contact them to discuss this.

Agreeing the points of complaint and outcome sought

44. It is important to be clear from the start of stage 2 about the points of complaint to be investigated and what outcome the customer is seeking. We may also need to manage the customer's expectations about the scope of our investigation.

45. Where the points of complaint and outcome sought are clear, we can confirm our understanding of these with the customer when acknowledging the complaint (see **Acknowledging the complaint**).

46. Where the points of complaint and outcome sought are not clear, we must contact the customer to confirm these. We will normally need to speak to the customer (by phone or face-to-face) to do this effectively. In some cases it may be possible to clarify complaints in writing. The key point is that we need to be sure we and the customer have a shared understanding of the complaint. When contacting the customer we will be respectful of their stated preferred method of contact. We should keep a clear record of any discussion with the customer.

47. In all cases, we must have a clear shared understanding of:

- **What are the points of complaint to be investigated?**

  While the complaint may appear to be clear, agreeing the points of complaint at the outset ensures there is a shared understanding and avoids the complaint changing or confusion arising at a later stage. The points of complaint should be specific enough to direct the investigation, but broad enough to include any multiple and specific points of concern about the same issue.

  We will make every effort to agree the points of complaint with the customer (alternative complaint resolution approaches may be helpful at this stage). In very rare cases, it may not be possible to agree the points of complaint (for example, if the customer insists on an unreasonably large number of complaints being separately investigated, or on framing their complaint in an abusive way). We will manage any such cases in accordance with our *[unacceptable actions policy, or equivalent]*, bearing in mind that we should continue to investigate the complaint (as we understand it) wherever possible.

- **Is there anything we can't consider under the CHP?**

  We must explain if there are any points that are not suitable for handling under the CHP (see **Part 2: What to do if the CHP does not apply).**

- **What outcome does the customer want to achieve by complaining?**

  Asking what outcome the customer is seeking helps direct the investigation and enables us to focus on resolving the complaint where possible.

- **Are the customer's expectations realistic and achievable?**

  It may be that the customer expects more than we can provide, or has unrealistic expectations about the scope of the investigation. If so, we should make this clear to the customer as soon as possible.

Notifying staff members involved

48. If the complaint is about the actions of a particular staff member/s, we will notify the staff member/s involved (including where the staff member is not named, but can be identified from the complaint). We will:

- share the complaint information with the staff member/s (unless there are compelling reasons not to)

- advise them how the complaint will be handled, how they will be kept updated and how we will share the complaint response with them
- discuss their willingness to engage with alternative complaint resolution approaches (where applicable); and
- signpost the staff member/s to a contact person who can provide support and information on what to expect from the complaint process (this must not be the person investigating or signing off the complaint response).

49. If it is likely that internal disciplinary processes may be involved, the requirements of that process should also be met and referred to the Standards Officer in respect of the Model Code of Conduct.

50. See also **Part 2: Complaints and disciplinary or whistleblowing processes.**

Investigating the complaint

51. It is important to plan the investigation before beginning. The staff member investigating the complaint should consider what information they have and what they need about:
    - what happened? (this could include, for example, records of phone calls or meetings, work requests, recollections of staff members or internal emails)
    - what should have happened? (this should include any relevant policies or procedures that apply); and
    - is there a difference between what happened and what should have happened, and is *Integration Joint Board* responsible?

52. In some cases, information may not be readily available. We will balance the need for the information against the resources required to obtain it, taking into account the seriousness of the issue (for example, it may be appropriate to contact a former employee, if possible, where they hold key information about a serious complaint).

53. If we need to share information within or outwith the organisation, we will be mindful of our obligations under data protection legislation. See **Part 1: Maintaining confidentiality and data protection.**

54. The SPSO has resources for conducting investigations, including:
    - **Investigation plan template**
    - **Decision-making tool for complaint investigators**

Alternative complaint resolution approaches

55. Some complex complaints, or complaints where customers and other interested parties have become entrenched in their position, may require a different approach to resolving the matter. Where we think it is appropriate, we may use alternative complaint resolution approaches such as complaint resolution discussions, mediation or conciliation to try to resolve the matter and to reduce the risk of the complaint escalating further. If mediation is attempted, a suitably trained and qualified mediator should be used. Alternative complaint resolution approaches may help both parties to understand what has caused the complaint, and so are more likely to lead to mutually satisfactory solutions.

56. Alternative complaint resolution approaches may be used to resolve the complaint entirely, or to support one part of the process, such as understanding the complaint, or exploring the customer's desired outcome.

57. The SPSO has **guidance on alternative complaint resolution approaches**.

58. If the Integration Joint Board and the customer (and any staff members involved) agree to using alternative complaint resolution approaches, it is likely that an extension to the timeline will need to be agreed. This should not discourage the use of these approaches.

Meeting with the customer during the investigation

59. To effectively investigate the complaint, it may be necessary to arrange a meeting with the customer. Where a meeting takes place, we will always be mindful of the requirement to investigate complaints (including holding any meetings) within 20 working days wherever possible. Where there are difficulties arranging a meeting, this may provide grounds for extending the timeframe.

60. As a matter of good practice, a written record of the meeting should be completed and provided to the customer. Alternatively, and by agreement with the person making the complaint, we may provide a record of the meeting in another format. We will notify the person making the complaint of the timescale within which we expect to provide the record of the meeting.

Timelines

61. The following deadlines are appropriate to cases at the investigation stage (counting day one as the day of receipt, or the next working day if the complaint was received on a weekend or public holiday):

    - complaints must be acknowledged within **three working days**
    - a full response to the complaint should be provided as soon as possible but not later than **20 working days** from the time the complaint was received for investigation.

Extension to the timeline

62. Not all investigations will be able to meet this deadline. For example, some complaints are so complex that they require careful consideration and detailed investigation beyond the 20 working day timeline. It is important to be realistic and clear with the customer about timeframes, and to advise them early if we think it will not be possible to meet the 20 day timeframe, and why. We should bear in mind that extended delays may have a detrimental effect on the customer.

63. Any extension must be approved by an appropriate manager. We will keep the customer and any member/s of staff complained about updated on the reason for the delay and give them a revised timescale for completion. We will contact the customer and any member/s of staff complained about at least once every 20 working days to update them on the progress of the investigation.

64. **Appendix 1** provides further information on timelines.

Closing the complaint at the investigation stage

65. The response to the complaint should be in writing (or by the customer's preferred method of contact) and must be signed off by a manager or officer who is empowered to provide the final response on behalf of the Integration Joint Board.

66. We will tell the customer the outcome of the complaint (whether it is resolved, upheld, partially upheld or not upheld). The quality of the complaint response is very important and in terms of good practice should:

    - be clear and easy to understand, written in a way that is person-centred and non-confrontational
    - avoid technical terms, but where these must be used, an explanation of the term should be provided
    - address all the issues raised and demonstrate that each element has been fully and fairly investigated
    - include an apology where things have gone wrong (this is different to an expression of empathy: see **the SPSO's guidance on apology**)
    - highlight any area of disagreement and explain why no further action can be taken
    - indicate that a named member of staff is available to clarify any aspect of the letter; and
    - indicate that if they are not satisfied with the outcome of the local process, they may seek a review by the SPSO (see **Signposting to the SPSO**).

67. Where a complaint has been **resolved**, the response does not need to provide a decision on all points of complaint, but should instead confirm the resolution agreed. See **Resolving the complaint.**

68. If the complaint is about the actions of a particular staff member/s, we will share with them any part of the complaint response which relates to them, (unless there are compelling reasons not to).

69. We will record the decision, and details of how it was communicated to the customer, on the complaints system.

70. The SPSO has guidance on responding to a complaint:

    - **Template decision letter**
    - **Apology guidance**

71. At the earliest opportunity after the closure of the complaint, the staff member handling the complaint should consider whether any learning has been identified. See **Part 4: Learning from complaints**.

Signposting to the SPSO

72. Once the investigation stage has been completed, the customer has the right to approach the SPSO if they remain dissatisfied. We must make clear to the customer:

    - their right to ask the SPSO to consider the complaint
    - the time limit for doing so; and

- how to contact the SPSO.

73. The SPSO considers complaints from people who remain dissatisfied at the conclusion of our complaints procedure. The SPSO looks at issues such as service failure and maladministration (administrative fault), and the way we have handled the complaint. There are some subject areas that are outwith the SPSO's jurisdiction, but it is the SPSO's role to determine whether an individual complaint is one that they can consider (and to what extent). All investigation responses must signpost to the SPSO.

74. The SPSO recommends that we use the wording below to inform customers of their right to ask the SPSO to consider the complaint. This information should only be included on the Integration Joint Board's final response to the complaint.

Information about the SPSO

The Scottish Public Services Ombudsman (SPSO) is the final stage for complaints about public services in Scotland. This includes complaints about *Integration Joint Board*. The SPSO is an independent organisation that investigates complaints. It is not an advocacy or support service (but there are other organisations who can help you with advocacy or support).

If you remain dissatisfied when you have had a final response from *Integration Joint Board*, you can ask the SPSO to look at your complaint. You can ask the SPSO to look at your complaint if:

- you have gone all the way through the *[organisation]*'s Complaints Handling Procedure
- it is less than 12 months after you became aware of the matter you want to complain about, and
- the matter has not been (and is not being) considered in court.

The SPSO will ask you to complete a complaint form and provide a copy of this letter (our final response to your complaint). You can do this online at **www.spso.org.uk/complain** or call them on Freephone 0800 377 7330.

You may wish to get independent support or advocacy to help you progress your complaint. Organisations who may be able to assist you are:

- Citizens Advice Bureau
- Scottish Independent Advocacy Alliance

The SPSO's contact details are:

SPSO

Bridgeside House

99 McDonald Road

Edinburgh

EH7 4NS

(if you would like to visit in person, you must make an appointment first)

Their freepost address is:

FREEPOST SPSO

Freephone: 0800 377 7330

Online contact **www.spso.org.uk/contact-us**

Website: **www.spso.org.uk**

Post-closure contact

75. If a customer contacts us for clarification when they have received our final response, we may have further discussion with the customer to clarify our response and answer their questions. However, if the customer is dissatisfied with our response or does not accept our findings, we will explain that we have already given them our final response on the matter and signpost them to the SPSO.

Appendix 1 - Timelines

General

1. References to timelines throughout the CHP relate to working days. We do not count non-working days, for example weekends, public holidays and days of industrial action where our service has been interrupted.

Timelines at frontline response (stage 1)

2. We will aim to achieve frontline response within five working days. The date of receipt is **day one**, and the response should be provided (or the complaint escalated) on **day five**, at the latest.

3. If we have extended the timeline at the frontline response stage in line with the CHP, the response should be provided (or the complaint escalated) on **day ten**, at the latest.

Transferring cases from frontline response to investigation

4. If the customer wants to escalate the complaint to the investigation stage, the case must be passed for investigation without delay. In practice this will mean on the same day that the customer is told this will happen.

Timelines at investigation (stage 2)

5. For complaints at the investigation stage, **day one** is:

   - the day the case is transferred from the frontline stage to the investigation stage
   - the day the customer asks for an investigation or expresses dissatisfaction after a decision at the frontline response stage; or
   - the date we receive the complaint, if it is handled immediately at stage 2.

6. We must acknowledge the complaint within three working days of receipt at stage 2 i.e. by **day three**.

7. We should respond in full to the complaint by **day 20**, at the latest. We have 20 working days to investigate the complaint, regardless of any time taken to consider it at the frontline response stage.

8. Exceptionally, we may need longer than the 20 working day limit for a full response. If so, we will explain the reasons to the customer, and update them (and any staff involved) at least once every 20 working days.

Frequently asked questions

What happens if an extension is granted at stage 1, but then the complaint is escalated?

9. The extension at stage 1 does not affect the timeframes at stage 2. The stage 2 timeframes apply from the day the complaint was escalated (we have 20 working days from this date, unless an extension is granted).

What happens if we cannot meet an extended timeframe?

10. If we cannot meet the extended timeframe at stage 1, the complaint should be escalated to stage 2. The maximum timeframe allowed for a stage 1 response is ten working days.

11. If we cannot meet the extended timeframe at stage 2, a further extension may be approved by an appropriate manager if there are clear reasons for this. This should only occur in exceptional circumstances (the orginal extension should allow sufficient time to realistically investigate and respond to the complaint). Where a further extension is agreed, we should explain the situation to the customer and give them a revised timeframe for completion. We must update the customer and any staff involved in the investigation at least once every 20 working days.

What happens when a customer asks for stage 2 consideration a long time after receiving a frontline response?

12. Unless exceptional circumstances exist, customers should bring a stage 2 complaint within six months of learning about the problem, or within two months of receiving the stage 1 response (whichever is latest). See **Part 2: Time limits for making a complaint.**

Appendix 2 – The complaint handling process (flowchart for staff)

A customer may complain verbally or in writing, including face-to-face, by phone, letter or email.

Your first consideration is whether the complaint should be dealt with at stage 1 (frontline response) or stage 2 (investigation).

Stage 1: Frontline response	**Stage 2: Investigation**
Always try to respond quickly, wherever we can	Investigate where: • The customer is dissatisfied with the frontline response or refuses to engage with attempts to handle the complaint at stage 1 • It is clear that the complaint requires investigation from the outset
Record the complaint and notify any staff complained about	Record the complaint and notify any staff complained about Acknowledge the complaint within **three working days**
	Contact the complainant to agree: • Points of complaint • Outcome sought • Manage expectations (where required) *(these can be confirmed in the acknowledgement where the complaint is straightforward)*
Respond to the complaint within **five working days** unless there are exceptional circumstances	Respond to the complaint as soon as possible, but within **20 working days** unless there is a clear reason for extending the timescale
Is the customer satisfied? You must always tell the customer how to escalate to stage 2	Communicate the decision, normally in writing Signpost the customer to SPSO and advise of time limits
(Yes) Record outcome and learning, and close complaint. *(No) -> to stage 2*	Record outcome and learning, and close complaint

Follow up on agreed actions flowing from the complaint

Share any learning points